UNITED STATES DEPARTMENT OF AGRICULTURE

FARM SECURITY ADMINISTRATION

OFFICE OF THE CHIEF MEDICAL OFFICER

ANNUAL REPORT

Fiscal Year July 1, 1940 - June 30, 1941

TABLE OF CONTENTS

INDEX OF TABLES

INDEX OF TABLES (cont'd.)

MEDICAL CARE STAFF

as of June 30, 1941

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Dr. R. C. Williams, Chief Medical Officer
Dr. F. D. Mott, Senior Medical Officer
Dr. E. W. Neenan, Dental Officer
Mr. D. W. Evans, Sanitary Engineer
Mr. J. B. Yaukey, Statistician
Miss Matilda Ann Wade, Supervising Nurse
Mr. K. E. Pohlmann, Health Services Specialist
Mr. H. R. Wood, Health Services Specialist (assigned)
Mr. J. P. Slater, Associate Sanitary Engineer

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Dr. C. M. Pearce, Dallas, Texas - Regions VI and VIII
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Dr. A. L. Ringle, Portland, Oregon - Region XI

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Mr. R. H. Riggin, Little Rock, Arkansas - Region VI
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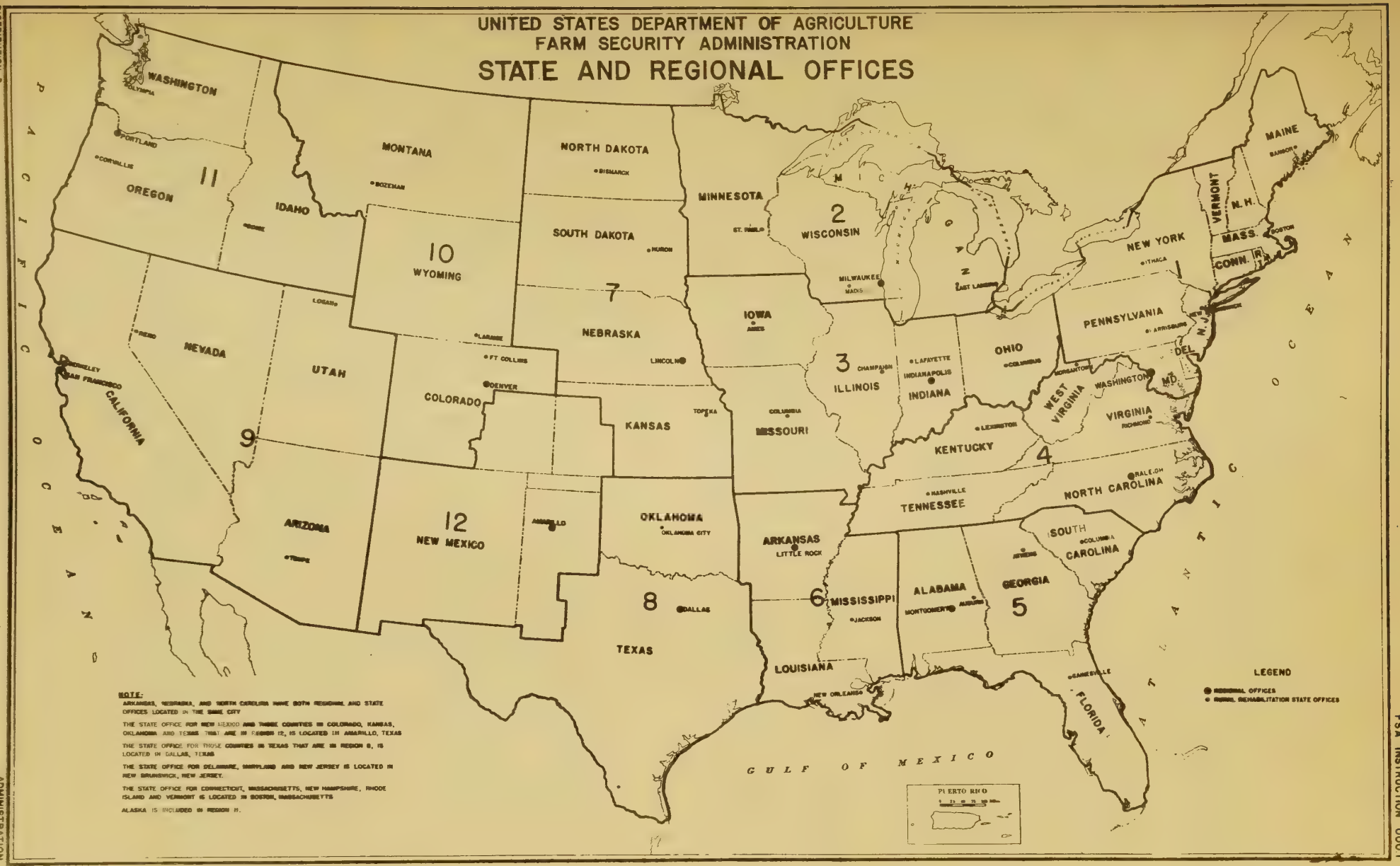
UNITED STATES DEPARTMENT OF AGRICULTURE
FARM SECURITY ADMINISTRATION
STATE AND REGIONAL OFFICES



NOTE:

ARKANSAS, NEBRASKA, AND NORTH CAROLINA HAVE BOTH REGIONAL AND STATE OFFICES LOCATED IN THE SAME CITY

THE STATE OFFICE FOR NEW MEXICO AND THOSE COUNTIES IN COLORADO, KANSAS, OKLAHOMA AND TEXAS THAT ARE IN REGION 12, IS LOCATED IN AMARILLO, TEXAS

THE STATE OFFICE FOR THOSE COUNTIES IN TEXAS THAT ARE IN REGION 8, IS LOCATED IN DALLAS, TEXAS

THE STATE OFFICE FOR DELAWARE, MARYLAND AND NEW JERSEY IS LOCATED IN NEW BRUNSWICK, NEW JERSEY.

THE STATE OFFICE FOR CONNECTICUT, MASSACHUSETTS, NEW HAMPSHIRE, RHODE ISLAND AND VERMONT IS LOCATED IN BOSTON, MASSACHUSETTS

ALASKA IS INCLUDED IN REGION II.

ADMINISTRATION
GENERAL

FSA INSTRUCTION 0001

REPORT FOR FISCAL YEAR JULY 1, 1940 - JUNE 30, 1941

OFFICE OF THE CHIEF MEDICAL OFFICER
FARM SECURITY ADMINISTRATION

FOREWORD

By June, 1941, the medical care and sanitation program of the Farm Security Administration was five years old. Since this fiscal year report offers an appropriate opportunity to take inventory, an effort has been made to list in considerable detail the 900 medical and dental care groups operating in June composed of more than 110,000 families who are borrowers from the Farm Security Administration. The special medical aid program for agricultural migrants, the study of the physical status of FSA borrowers, and the expanding environmental sanitation program are also treated in some detail in sections of this report.

Four and a half million farm families, three-fourths of the entire agricultural population of the United States, had net cash incomes of less than one thousand dollars in 1940. It is particularly for this group that there is significance in the patterns being evolved to meet the health needs of rural rehabilitation and tenant purchase borrowers, resettlement project occupants, and migrant agricultural workers.

Medical Care Program for FSA Borrowers

The social and economic hazards of sickness and its costs are being challenged today by thousands of farm families. It is an organized challenge--not the ineffective effort of individuals acting alone, but an encouraging example of intelligent group action. By pooling their limited financial resources, these families have been able to reach an understanding with the various professional groups concerned with medical care in their communities. This gives them more ready access to facilities for various types of medical services.

The past fiscal year saw continued expansion of this medical care program. By June, 1941, 104,224 families were enrolled--over 545,000 persons. The 703 groups organized among these families extended into 881 counties in 35 states. They were made up of rural rehabilitation borrowers for the most part, but also included families in other FSA categories such as tenant purchase and resettlement project families.

There is evidence of increasing approval of the program on the part of organized medicine, an acknowledgment that the organization of payment for medical services need not interfere with the physician-patient relationship.

Dental Care Program for FSA Borrowers

Faced with the staggering problem of almost universal neglect of dental needs among its borrowers, the Farm Security Administration has been experimenting with a rather wide variety of approaches to the problem in collaboration with state and local dental societies. Because of limited funds, based on family contributions, and because of the nature of the problem, the program so far has been largely of an emergency character. The chief emphasis has been on eradicating sources of infection. That dental disease can be attacked effectively only by a program of prevention and control is recognized, however, and such an approach awaits only some practicable method of financing.

Dental care was first made available to FSA families on a prepayment basis as part of various medical care plans. Emergency dental service, confined largely to extractions, was included in a considerable number of plans because of the necessity for eliminating, in so far as possible, the systemic effects of dental disease. As of June, 1941, 15,493 families were enrolled in medical care groups which included emergency dental service within the scope of the various medical services offered.

There has been increasing recognition of the desirability of organizing separate and more complete dental care plans and during the past fiscal year there was an accelerated expansion of a separate dental care program developed in cooperation with state and local dental societies. As of June, 1941, there were 159 separate dental care groups in 167 counties in 14 states. The total enrollment of these separate groups was 23,450 families or 124,021 persons. The services in many of these plans included fillings, particularly for children, as well as extractions and soft tissue treatments to eradicate infection. A few plans included other types of restorative dentistry.

Health Program for Resettlement Projects

The resettlement projects offer an opportunity to develop a broader and yet more concentrated health program than is readily attainable when dealing with widely scattered farm families. In general there is decent housing and adequate sanitation in the projects, and a background of community organization offering a ready-made field for health education efforts.

Health centers have been placed in many projects, and more than fifty projects are served by full-time community nurses. The nursing program, carried out with the cooperation of health departments and practicing physicians, constitutes a broad form of generalized public health nursing including some bedside care and demonstration work in maternity and acute illness cases.

During the fiscal year the medical care program was extended to 19 additional resettlement projects, making a total of 75 projects with

medical care groups. There were 35 projects with separate medical care units, 37 with units combined with rehabilitation families, and 3 with both separate and combined units serving the project families. Families enrolled in separate units numbered 4,148, and there were 1,037 project families in combined units, or a total of 5,185 resettlement project families taking an active part in the medical care program.

Medical Care for Migratory Agricultural Workers

Since the spring of 1938 the Farm Security Administration has been providing medical aid for migrant agricultural workers in California and Arizona through the Agricultural Workers Health and Medical Association, a corporation financed by the Farm Security Administration. During the past fiscal year similar medical aid programs were established for migrants in Florida, the Rio Grande Valley in Texas, and the Pacific Northwest.

In these more recently organized programs the medical aid is furnished through clinics in the migratory labor camps and by referral from the clinics. The effect of this is to make medical care available chiefly to camp occupants and migrants in the vicinity of the camps, whereas, in California and Arizona , the medical benefits have been extended not only through camp clinics but through district referral offices to migrant families throughout wide areas in both states.

Physical Status of FSA Borrowers

The physical examination studies previously undertaken were continued during the past fiscal year. With completion of the seventeen-state study of 2,480 borrower families, detailed information concerning the physical status of low-income farm families is becoming available. Although the report of this study has not yet been completed, some of the significant findings are incorporated in a section of this report. As in the case of rejected draftees, the striking feature of the numerous physical defects found is that the great majority might have been prevented or might still be remedied.

Environmental Sanitation

It has been estimated that of the six million farms in the United States, approximately five and a half million are in need of some corrective measures to insure a safe farm water supply; that proper methods for the disposal of human wastes are lacking on four and a half million farms; and that four million farm dwellings are in need of either mosquito or fly proofing for controlling the transmission of certain diseases. Since these three fundamentals of sanitation are basic in a public health program, it is clearly indicated that the surface of the problem of rural sanitation has barely been scratched.

With the full realization of the problems ahead and with the knowledge that the lack of sanitary facilities is a major factor in the rehabilitation of farm families, the Farm Security Administration several years ago embarked on a program to do something about it. After experience in the operation of an environmental sanitation program, it is recognized that it is not a simple problem easily solved; that the remedy is tied in closely with that of land tenure, soil preservation and conservation, housing, food and clothing and medical care. Closely associated with all these factors is the economic stability of the farm family. It is clearly indicated that other governmental agencies must play a part in the environmental sanitation program, if the program is to succeed. The Farm Security Administration recognizing this has enlisted the aid of such agencies as the State and County Health Departments, Work Projects Administration, National Youth Administration, Extension Service, Soil Conservation Service, and Forest Service.

In the section of this report on environmental sanitation, the progress which has been made during the fiscal year 1940-41 is outlined. Much still remains to be done.

AGREEMENTS WITH STATE MEDICAL ASSOCIATIONS

THROUGH JUNE 1941

REGION I

Maine Medical Association	January, 1939 (limited to one county) June, 1940 (general agreement)
Medical and Chirurgical Faculty of Maryland	1939
New Hampshire Medical Society	November, 1938 (informal)
Medical Society of New Jersey	October, 1938 (Welfare and Medical Practice Committees) June, 1940 (Board of Trustees)
Medical Society of the State of New York	September, 1939 (Council) May, 1940 (House of Delegates)
Medical Society of the State of Pennsylvania	October, 1939
Vermont State Medical Society	October, 1938

REGION II

Michigan State Medical Society	October, 1940 (approved negotiations with Michigan Medical Service - which resulted in agreement in May, 1941)
Minnesota State Medical Association	February, 1941 (limited to three counties)
State Medical Society of Wisconsin	January, 1938 (FERA fee schedule)

REGION III

Illinois State Medical Society	May, 1937
Indiana State Medical Association	April, 1937 (common fund plans approved in November 1938)
Iowa State Medical Society	July, 1937 (agreement liberalized in November, 1938)
Missouri State Medical Association	May, 1937 (liberalized in 1939)
Ohio State Medical Association	July, 1937 (liberalized in 1939)

REGION IV

Kentucky State Medical Association	June, 1939
Medical Society of the State of North Carolina	December, 1937
Tennessee State Medical Association	December, 1937
Medical Society of Virginia	October, 1938
West Virginia State Medical Association	December, 1938

REGION V

Medical Association of the State of Alabama	January, 1938
Florida Medical Association	January, 1939
Medical Association of Georgia	March, 1938
South Carolina Medical Association	December, 1938

REGION VI

Arkansas Medical Society	1937
Louisiana State Medical Society	October, 1938
Mississippi State Medical Association	May, 1937 May, 1939 - resolution of disapproval May, 1940 (clarifying ruling which again furnished basis for working agreement)

REGION VII

Kansas Medical Society	January, 1939 (informal)
Nebraska State Medical Association	May, 1939
North Dakota State Medical Association	Spring, 1940 (plans subject to approval of State Association)
South Dakota State Medical Association	1939 (agreement is with Inter-Allied Professional Council of South Dakota)

REGION VIII

Oklahoma State Medical Association	November, 1936 (special fee schedule) September, 1937 (general agreement)
State Medical Association of Texas	January, 1938

REGION IX

Arizona State Medical Association	April, 1939
California Medical Association	March, 1941 (agreement with California Physicians' Service)
Utah State Medical Association	May, 1937 April, 1939 (agreement with Medical Service Bureau)

REGION X

Colorado State Medical Society	September, 1938
Medical Association of Montana	December, 1939
Wyoming State Medical Society	April, 1939

REGION XI

Idaho State Medical Association	June, 1941
Oregon State Medical Society	September, 1939 (plans subject to approval of State Society)
Washington State Medical Association	April, 1939

REGION XII

Colorado State Medical Society	September, 1938 (listed under Region X)
Kansas Medical Society	January, 1939 (listed under Region VII)
New Mexico Medical Society	June, 1938
Oklahoma State Medical Association	September, 1937 (listed under Region VIII)
State Medical Association of Texas	January, 1938 (listed under Region VII)

RECAPITULATION

Definite working agreements or understandings in effect with 34 state medical associations.

Informal or limited agreements in effect with 9 other state medical associations.

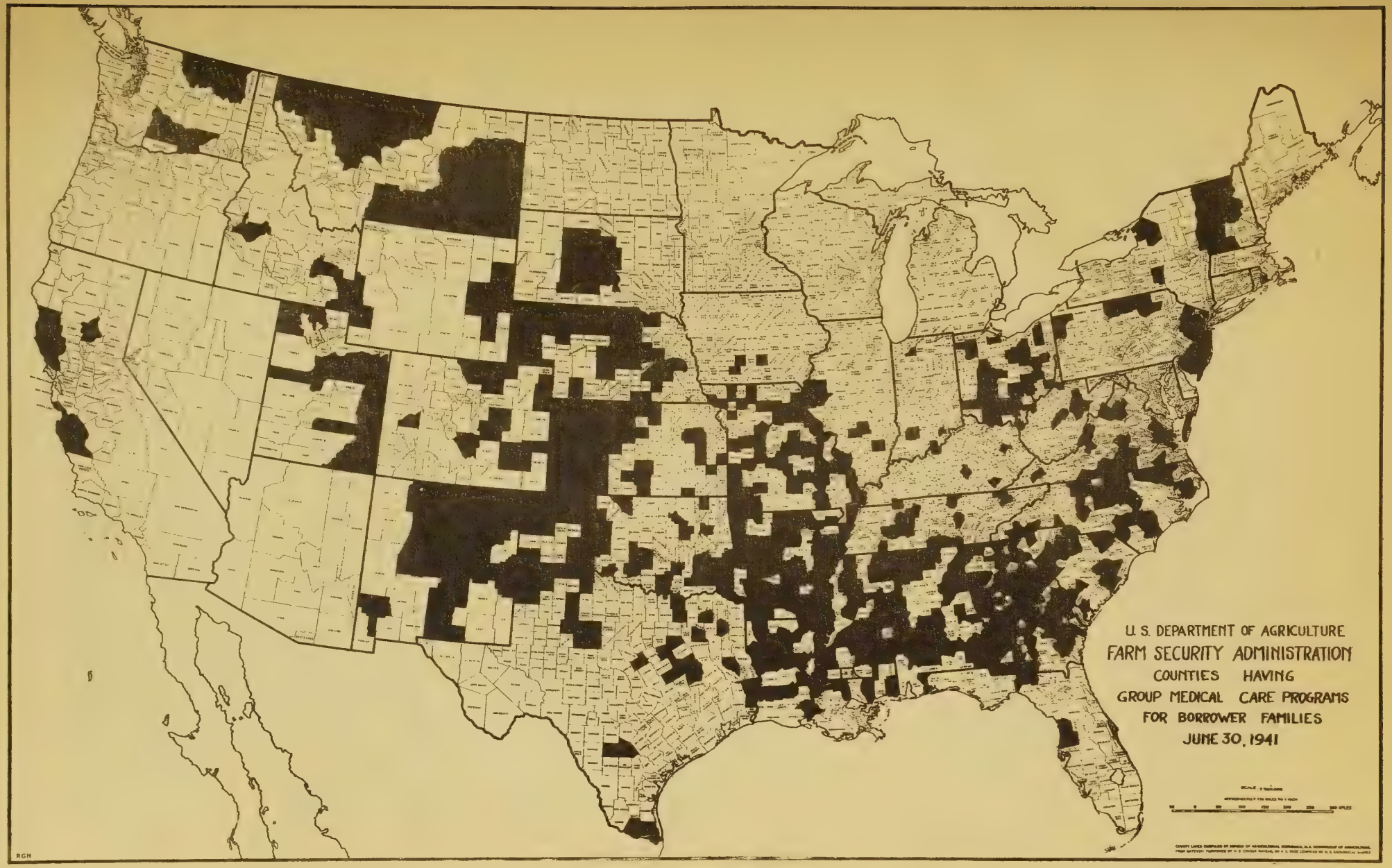
Total number of state medical associations with which working agreements, some informal or limited, have been reached through June, 1941 --- 43.

Table No. 1

States having group medical care units serving FSA borrowers (except units restricting membership to resettlement projects) showing the number of counties having such plans operating in June of each year from 1936 through 1941.

Region and State	NUMBER OF COUNTIES					
	June 1936	June 1937	June 1938	June 1939	June 1940	June 1941
All States	8	142	203	514	639	881
Region I				1	19	46
New Hampshire					2	2
New Jersey				1	1	19
New York						4
Pennsylvania					2	7
Vermont					14	14
Region III		1	5	31	55	116
Illinois					5	10
Indiana				5	4	6
Iowa		1	2	3	1	3
Missouri			2	12	28	56
Ohio			1	11	17	41
Region IV				25	84	102
Kentucky					4	3
North Carolina				10	35	38
Tennessee				7	10	20
Virginia				8	28	34
West Virginia					7	7
Region V	1	2	6	153	164	187
Alabama			3	23	33	40
Florida				5	5	6
Georgia	1	2	3	108	108	121
South Carolina				17	18	20
Region VI	7	17	60	112	131	148
Arkansas	5	14	56	67	68	59
Louisiana			1	7	21	30
Mississippi	2	3	3	38	42	59
Region VII		122	122	122	43	85
Kansas					20	28
Nebraska					23	43
North Dakota		53	53	53		
South Dakota		69	69	69		14

Region and State	NUMBER OF COUNTIES					
	June 1936	June 1937	June 1938	June 1939	June 1940	June 1941
Region VIII			4	19	52	49
Oklahoma			4	11	23	22
Texas				8	29	27
Region IX			1	1	4	16
California						7
Utah			1	1	4	9
Region X				4	9	43
Colorado				2	3	7
Montana				2	2	30
Wyoming					4	6
Region XI			4	2	1	11
Idaho			4	2	1	5
Washington						6
Region XII			1	44	72	76
Colorado					3	6
Kansas				25	25	24
New Mexico				7	22	20
Oklahoma				1	1	3
Texas			1	11	21	25


U. S. DEPARTMENT OF AGRICULTURE
FARM SECURITY ADMINISTRATION
COUNTIES HAVING
GROUP MEDICAL CARE PROGRAMS
FOR BORROWER FAMILIES
JUNE 30, 1941
RGH

MEDICAL CARE PROGRAM FOR FSA BORROWERS

Basic to the general health work of the Farm Security Administration is the medical care program for borrower families which has been developed in close cooperation with the medical profession. Starting slowly in 1936 and 1937 this program now serves more than 100,000 farm families in thirty-five states.

Background. From the early days of the rehabilitation program it was evident that poor health and physical disability were among the primary factors keeping many families from becoming self-supporting. Lack of medical facilities and lack of ability to pay for such medical services as did exist were two of the underlying difficulties. These families lacked adequate medical care because they could not pay for it and they lacked adequate facilities for medical care because their incomes were too low to help maintain these facilities.

The various surveys and studies conducted in recent years by public and private agencies have thrown into the spotlight the serious medical care problems confronting rural families, particularly those with low incomes. In general, it has been shown that the volume of medical care which people receive decreases with the size of city in which they reside and that families in rural areas receive least of all. A similar reduction in the volume of medical care has been noted with decrease in size of income. The low income rural family is, therefore, subjected to forces from two directions cutting down the amount of medical care available to the family. This situation prevails in such varying fields as general practitioner care, surgery, hospital care, eye refractions, dental care, and smallpox vaccinations. Notwithstanding this reduced amount of medical care received by rural residents, available data indicate that the expenditures of these rural families for medical care are not markedly different from those of urban families with comparable incomes.

Surveys and studies, including the physical examination study referred to elsewhere in this report, only confirm what is common knowledge to the supervisors working with these low-income families. They have seen farmers dragging along for years with some partially disabling chronic condition. They know that many of these people hesitate to consult their physicians, knowing that they could not pay the bills. Minor ailments have often been uncared for until they became grave, and then a family's livestock or farm tools have had to be sold at a sacrifice to pay for a surgical operation or prolonged hospital care.

Because it is unpredictable, acute sickness often has thrown out of balance the carefully developed plan charting a family's course toward economic rehabilitation. The aim of the medical care program is to make necessary medical care readily available to all of the families receiving financial and supervisory assistance from the Farm Security Administration and to lessen the financial impact of sickness by

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providing a mechanism whereby the families may budget a definite amount for services of the widest practicable scope.

Basic Principles. Over the five-year period during which the program has been developing there has been little deviation from the following broad principles laid down at the beginning:

1. Free choice of physician. The general policy is to develop no medical service plans in a state until a basic working agreement has been reached with the state medical association. Then county or district plans are organized in collaboration with local medical societies. The plans provide for medical society supervision over medical aspects of the program. Enrolled borrowers have free choice of physician from among those participating, usually from among all legally qualified physicians in the area. There is no interference with the personal relationship between physician and patient.

2. Group prepayment. Family participation dues are paid in advance on an annual basis. Borrowers are often assisted in making such payments, ordinarily through loans. The funds deposited by each family are placed in a pooled or common fund in the hands of a bonded treasurer or trustee, and from monthly or quarterly allotments of this fund payments are made to physicians, hospitals and druggists.

3. Family contributions based on average incomes. Participation rates are in general commensurate with average incomes of FSA borrowers in the area. The rates for a particular plan depend on the services covered and often upon the size of family as well as upon average income. When a given rate is beyond the ability of a family or a group of families to pay, an effort is made to base the family contribution on its ability to pay and some provision is made for supplementing this amount to the extent necessary.

4. Voluntary Participation. The borrowers are never compelled to participate. The local plan is presented to them; whether or not they become members is entirely for their decision. But in most cases economic necessity itself is a compulsion — they cannot afford not to participate.

Agreements with State Medical Associations. A working agreement or understanding with each state medical association has been considered a prerequisite to the development of local medical service plans. Additional progress was made during the past fiscal year in securing basic agreements or understandings with state medical associations. The number of these associations with which understandings of varying scope were in effect each fiscal year for the past five years is as follows:

June 1937	-	8	June 1939	-	34
June 1938	-	18	June 1940	-	39
			June 1941	-	43

The four new working agreements obtained during the fiscal year were with the Michigan State Medical Society, the Minnesota State Medical Association, the California Medical Association and the Idaho State Medical Association. The Michigan State Medical Society and the California Medical Association designated the medical service organizations which they have sponsored — the Michigan Medical Service and the California Physicians' Service — as the agencies authorized to cooperate with the Farm Security Administration. The agreement with the Minnesota State Medical Association is limited in scope, being confined to approval by the Association of an experimental program which is to receive a thorough trial in three counties in the State before it is extended to other areas. The Idaho State Medical Association has gone on record as permitting its constituent county medical societies to work out plans for medical care groups with the Farm Security Administration if they desire to do so.

The negotiation of agreements has been postponed in the case of state medical associations in five states which have relatively low caseloads of FSA borrowers, namely, Massachusetts, Connecticut, Rhode Island, Delaware, and Nevada.

A list of the agreements with various state medical associations with the dates of the agreements follows the introduction of this report.

Expansion of Medical Care Program During the Fiscal Year. The progress made in preceding fiscal years in extending the medical care program into additional states and counties was continued during the fiscal year 1940-1941. Table No. 1, which precedes this section of the report, illustrates by regions and states the growth of the program from June, 1936 to June, 1941, except for medical care units restricting membership to occupants of resettlement projects. The total number of states and counties to which this program had been extended as of the last month of each fiscal year since June, 1936, is as follows:

Number of States and Counties with Medical Care Groups of FSA Borrowers

	June 1936	June 1937	June 1938	June 1939	June 1940	June 1941
States	3	6	14	25	31	35
Counties	8	142	202	514	639	881

Detailed data relative to the growth of this program during the past fiscal year by regions and states are included in Table No. 2. There was an over-all net increase of 26,171 families enrolled, representing an increase of 33.5 percent. As of June 30, 1941, 104,224 families were active participants, including 60.5 percent of all eligible FSA families in the areas covered. The following is an abstract from Table No. 2 showing the increase in the number of medical care units, the number of counties covered by the units, and the number of participating families and persons:

	States	Units	Counties	Families	Persons
June, 1941	35	703	881	104,224	545,673
June, 1940	31	546	639	78,053	418,382
Increase	4	157	242	26,171	127,291

In addition to the medical care units in the thirty-five states listed in Table No. 2, units were to go into effect in three additional states during the first few weeks of the following fiscal year.

Membership Growth in Individual Units. Most of the expansion which took place during the fiscal year was naturally due to the addition of new medical care units. However, it was felt that it was important to measure the growth of units already established as a test of the vitality of the program. For this reason, the data assembled in Table No. 3 were obtained for those medical care groups which were operating both in June, 1940 and in June, 1941.

The experience of the 487 units for which records are available reveals a net increase of 10.6 percent in the number of enrolled families, with 36.5 percent of the eligible FSA families in the areas concerned not yet enrolled.

Although there was an over-all net increase of 10.6 percent in family enrollment, there was a decrease in the number of participating families in these established units in 13 of the 31 states represented.

The best over-all record was made by the groups in Regions III, IV, and VI. In Region III there was a net gain of 33.4 percent in the number of families enrolled, with no state in the Region showing a decreased enrollment. However, even with this gain, the total enrollment of these units at the end of this period was only 36 percent of the families eligible for a membership in the 47 counties covered. In Region VI there was a 30.3 percent gain, with no state showing a loss. In Region IV there was a 26.7 percent over-all gain in the number of members, despite the decrease in one state, Virginia.

The most unsatisfactory record with respect to these continuing units was made by Regions I, V, VII, and XII. In Region VII there was a 15.7 percent decrease in enrollment, with both states represented showing a loss. In Region XII there was a 6.1 percent decrease, with two out of five states showing losses. In Region I there were net losses in enrollment in three out of four states, although there was an over-all increase of 10.7 percent in the four states as a whole. Region V had a drop in enrollment in three out of four states, with an over-all net increase of 4.7 percent, but this must be considered in the light of the fact that the enrollment in these Region V units stood at 81 percent of all families eligible as of June, 1941.

Units Terminated During Fiscal Year. Excluding a number of medical care units suspended temporarily during the fiscal year and operating again by June, 1941, there were 44 units terminated during the year which had been in operation in June, 1940. These 44 units represented 8.1 percent of the 546 units in active operation at the outset of the fiscal year. The following table shows the experience of the seven regions in which the termination of units occurred.

No. of Units Operating in June, 1940 and No. and Percent of these Units Terminated During Fiscal Year 1940-1941

	Units June, 1940	Units Terminated	Percent Units Terminated
Region III	53	7	13.1
Region IV	61	8	13.1
Region V	162	6	3.7
Region VI	130	13	10.0
Region VIII	50	7	14.0
Region X	8	1	12.5
Region XII	31	2	6.5

Several reports concerning terminated units have indicated that renewal of the program could be expected after necessary readjustments had been effected. The future experience in the counties in which the 44 units were terminated or suspended will be observed closely.

Factors Underlying Membership Losses and Termination of Units. The factors underlying the decreases in membership in 13 states and in many units in the other 18 states cannot be evaluated authoritatively without further study and analysis. However, it is possible to discuss some of the more obvious factors as revealed by field experience of personnel engaged in medical care activities. In most instances these have been the same factors, somewhat intensified, that have been responsible for the suspension or termination of units. These factors may be related to the three interested groups: the FSA personnel, the families, and the physicians. It would be an error to consider these factors universal, as there are gratifying exceptions in many districts, but in varying degree they apply rather generally.

The shortcomings of FSA personnel sometimes encountered may be summed up as: (a) lack of thorough understanding of the medical care program; (b) failure to consider program an integral part of their rehabilitation efforts; (c) allowing pressure of other work to prevent giving adequate time to program; (d) apathy and indifference in some instances; (e) failure to provide for renewed participation in farm and home plans; (f) lack of effort to establish a close working relationship with physicians; and (g) viewpoint that the program is the sole responsibility of specialized personnel. These factors, which are inter-related, add up to a failure to assume proper responsibility for developing and maintaining the program. They have a direct bearing on the attitude of

borrowers toward the program. They are factors which operate in the regional and state offices as well as in the district and county offices.

Some of the factors underlying membership losses which pertain to the enrolled families include: (a) the understandable feeling, which may be subconscious, that they are not part of the plan, that the plan is superimposed and is not their plan — a feeling which stems from lack of direct representation during the planning stage and often during the operating stage — and the related factor of lack of sufficient knowledge of details of the plan and its purpose; (b) tendency to withdraw following a year when no medical service is needed; (c) disinclination to add further to their debt structure by borrowing funds for participation; and (d) family physician not taking part in plan.

There may be a direct relationship between a dwindling membership or a terminated unit and the local situation in the medical society or among individual physicians. Some of the more specific reasons underlying the termination of certain units are listed in the review of activities in Regions IV, VI, and VIII. Many difficulties have been due to a lack of understanding on the part of the physicians of the objectives not only of the medical care program but of the general rehabilitation program, a shortcoming which can hardly be blamed on the physicians. Some physicians find it difficult to adjust their thinking to the group prepayment principle. At times there has been trouble because physicians have treated the borrowers as though they were objects of relief or charity. In a number of instances units have been terminated or suspended as a direct result of disagreements between individual physicians or between factions in a county medical society. Many of these difficulties could be obviated if there were always a strong medical advisory or review committee with the courage of its convictions, and if the medical society and its members were willing to give the local plan a fair trial. It is generally true that smoothly running, successful plans are found to have strong medical advisory committees.

Another difficulty encountered recently is that of physicians leaving the rural areas to go into military service. Units have been terminated because of the sheer lack of available physicians in given areas. The defense activities have simply accentuated an existing problem relative to the shortage of rural physicians and the long distances which the few practicing physicians in many areas have to travel to make home calls.

Families in Program by FSA Classification. In assembling data relative to active medical care units, an effort has been made to secure accurate statements from the field regarding the enrollment of FSA families in various categories. Information regarding the number of eligible families and the number of enrolled families has been summarized in Table No. 4 for rural rehabilitation borrowers, resettlement project

occupants, other FSA (including tenant purchase) families, and non-FSA families. The figures given for eligible and enrolled "other FSA families" doubtless include certain categories of rehabilitation families other than active standard cases, as well as tenant purchase borrowers. The following is an abstract from Table No. 4 showing the breakdown of the enrolled group for the country as a whole and the percent of eligible families enrolled:

	Eligible Families in Counties with Units	No. of Families Enrolled	Percent Enrollment
Rehabilitation borrowers	157,071	98,263	62.6
Resettlement project occupants	1,663	1,037	62.4
Other FSA (including TP) families	11,583	3,813	32.9
Non-FSA families		1,111	
	170,317	104,224	60.5*

*Non-FSA membership omitted in computing this percentage.

All data in this part of the report are exclusive of data pertaining to medical care groups which restrict membership to resettlement project occupants. The data given above relative to resettlement project families are for those medical care units which combine resettlement families in their membership with rehabilitation and other FSA families. As of June, 1941, resettlement families from 40 resettlement projects were combined in units of this type with other families on the FSA rolls.

In addition to 1,037 resettlement project families enrolled in 40 combined units, 4,148 other project families were enrolled in 38 separate units as of June, 1941, making a total of 107,261 FSA families in 741 medical care groups, and a total of 108,372 member-families including non-FSA families.

The Farm Security Administration has not taken the initiative in connection with the enrollment of 1,111 non-FSA families in various units. This matter is duscussed in the review of activities in Montana, Nebraska and Utah. The addition of low income non-FSA families not only meets with the approval of the physicians in the few areas concerned, but it has been done at their request. Some of the 1,111 families are former FSA borrowers who have paid their loans in full but who are still entitled to medical services until their current memberships expire.

Percent of Eligible FSA Families Enrolled. That participation is voluntary in these 703 medical service plans requires no proof other than the fact that 60.5 percent of eligible FSA families in the 881 counties constituted the total FSA enrollment in the plans as of June 30, 1941.

The percentage of enrollment was over 60 percent in only two regions, and it was under 50 percent in five of the eleven regions with active units.

Percentage of Enrollment of FSA Families in Counties with Units

All Regions	60.5		
Region I	50.8	Region VIII	49.6
Region III	38.6	Region IX	55.5
Region IV	46.9	Region X	43.2
Region V	84.3	Region XI	45.3
Region VI	66.9	Region XII	56.3
Region VII	55.6		

The factors responsible for low participation in a given unit or in a region as a whole are much the same as those underlying membership losses or the termination of units. The battle for adequate participation is half-won when there are administrative determinations in a region which result in the realization that the health program is an integral part of rehabilitation. The battle finally will be won when FSA personnel not only come to this realization but when in translating it into action they draw upon the latent resources of the borrowers — the farmers and their wives. These families have within themselves largely untapped sources of interest, energy, and perseverance in this cause which affects them so directly.

Forms of Organization. In general, there are two fairly distinct forms of organization in the medical care units, trusteeships and health associations.

In a simple trusteeship there is no definite organization which the families join as members, although there may be an elected or selected "advisory committee" or "governing body" of borrowers representing their interests. The borrowers sign participation agreements designating someone as trustee to represent their interests and to administer the medical care fund. The trustee is usually a "neutral" person who is neither a borrower, a physician, nor an FSA representative.

Where health associations of borrowers have been organized, they are ordinarily informal, unincorporated associations. The boards of directors are elected by the members at county-wide or neighborhood meetings. In certain states there are FSA representatives on these boards. The medical care funds are administered either by the tresurer of the association who may as a rule be a non-member, or by a trustee approved by the board, the medical society and FSA representatives.

In some district plans, such as those in Montana, there is a health association unit in each county or in each area served by an FSA county office, with an over-all district association to deal with the physicians on a district basis. This type of organization provides a mechanism whereby local initiative and local responsibility are fostered.

As of June, 1941, trusteeships constituted the form of organization in 455 of the 703 medical care units exclusive of separate resettlement project units, and associations of borrowers had been organized in the 248 other units. All of the units in Regions I, III, IV, and V were trusteeships. All in Regions VII, VIII, IX, X, and XI were associations, many of them very informal in character. In Regions VI and XII there were both trusteeships and associations, there being a preponderance of associations in Region VI and a greater proportion of trusteeships in Region XII.

County, District and Statewide Units. Of 703 medical care units in operation in June, 1941, 623 or 88 percent were limited geographically to one county each. Of the remaining 80 units, 52 were two-county units, 14 were three-county units, nine extended to from four to six counties, and five comprised ten or more counties each. Two of the large district plans were statewide -- the Vermont program (14 counties) and the New Jersey program (members from 19 of the 21 counties). The other three large district units were in southwest Kansas, Montana, and South Dakota.

District plans covering more than one county are almost essential when there is a small, scattered caseload. Even when the caseload is substantial, there are obvious advantages inherent in district plans, related first to "spreading the risk," i.e., broadening the "insurance" base, and second, to simplifying the task of negotiating with professional groups which are frequently organized on a district basis. A small unit with but 50 or 60 member-families often operates with surprising stability in so far as the provision of general practitioner care is concerned, but it is necessary to have a broader base if hospitalization and surgical care bills are to be handled satisfactorily. Moreover, a district plan makes possible more efficient business administration, for it offers a substantial financial inducement to the trustee who administers the medical care fund.

The serious weakness of a poorly organized district plan is found in the lack of acceptance of responsibility by FSA personnel, borrowers, and physicians. The temptation to take shortcuts, to neglect the all-important educational work among these three groups locally, may ultimately prove disastrous. Local responsibility is fundamental. There must be local borrower representation, through a county association or committee constituting a unit of the larger organization, and there must be local advisory committees of physicians as well as an over-all district committee except in districts of moderate size with relatively

few physicians. If these conditions are to be met, local FSA personnel must play an active part -- the third factor essential to the successful operation of a district plan.

Scope of Services Offered in Medical Care Groups. Because of the limited ability of borrower families to pay for medical care, the emphasis during the early years of the program has necessarily been on providing primarily the care essential to the treatment of acute illness, but, in so far as possible, provision has also been made for the correction of chronic defects which constitute a retarding factor in rehabilitation.

The scope of services offered in each region is shown on the graph which follows Table No. 4. Moreover, Table No. 5 includes data relative to the various combinations of services which are offered in the various states and regions, and Table No. 6 indicates the scope of the service offered in each medical care unit. Although, in general, there is emphasis on developing plans covering services of the widest practicable scope and on expanding the services offered in existing plans, nevertheless there are certain regional and state differences in the scope of services offered which are due to a considerable extent to the availability outside of the FSA program of certain services for the medically indigent. For example, free or low cost hospitalization and surgical care are available to medically indigent families, including most FSA borrowers, in certain states such as Pennsylvania, North Carolina, Mississippi, and Louisiana.

It will be noted in Tables No. 5 and 6 that the services offered are broken down into five categories, i.e., physicnas' care, surgeons' care, hospitalization, drugs, and dental care.

"Physicians'" services may be taken to include those services ordinarily rendered by a general practitioner, that is, office, home, and obstetrical care.

"Surgeons'" services relate in many units strictly to major surgical services rendered hospitalized patients, as a rule, cases of an acute or emergency character. In some units this category of service includes not only surgical care but the care of other specialists or even of general practitioners rendered in the case of hospitalized patients.

"Hospital" service refers as a rule to ward care, and the benefits ordinarily include such services as the use of operating room and the performance of routine laboratory examinations. There is often a limitation in the number of days of care provided in a given case or provided for an individual or a family on an annual basis.

When "drugs" are listed as included in the services offered in a given unit, the implication is that some definite provision has been made for the furnishing of ordinary medicines, usually including prescribed drugs.

In a large number of other units, such drugs as the physicians themselves ordinarily dispense are included in the benefits even though "drugs" may not be listed among the services.

"Dental" care, when listed with the services provided in these medical care units, refers to very limited emergency dental care, usually extractions indicated to relieve pain or eradicate infection, except in a few units such as certain units in Region VII where $4 of each family's membership fee is set aside in a separate fund to pay for fillings for children as well as for emergency extractions. There is a definite trend toward developing separate dental care plans rather than including dental services in the medical care plans.

The following table shows for the 104,224 families enrolled in June, 1941, the number of families entitled to services in the five different categories and the percentage of all participating families entitled to each type of service:

Type of Service	No. of Families	Percent of Enrolled Families
Physicians' care	103,770	99.6
Surgeons' care	71,055	68.3
Hospitalization	64,492	61.8
Drugs	54,066	51.9
Dental care	15,493	14.9

In most medical care units there are limitations in the services provided in the case of chronic illness and pre-existing conditions. These limitations relate primarily to hospitalized cases, although some of the plans for general practitioner care include a limitation of but one office or home call per week in the case of chronic illness. An encouraging beginning, however, has been made in including those services essential to the treatment of chronic or pre-existing conditions which may constitute a hazard to the health of the individual or a retarding factor in rehabilitation. For example, the Montana program includes "all reasonable medical and surgical services", and the California program includes the care of any chronic conditions found in children under 18 years of age. Moreover, in certain other plans, such as those in effect in some counties in Region III and Region VII, and in the revised program in southwest Kansas in Region XII, provision is made for the necessary care of conditions threatening health or rehabilitation. It is noteworthy that in certain areas the physicians themselves are insisting that the local plans cover a scope of service broader than that now in effect.

Annual Membership Rates. In Table No. 5 the average annual membership rates are listed for different combinations of services in each state and region and in the United States as a whole. In Table No. 6 the average annual membership rate is given for each medical care unit.

Virtually all membership rates were determined locally by regional, state, and local FSA personnel in conference with the physicians concerned. But out of this wide variety of rates established for various combinations of services in widely scattered localities, there has come about a certain degree of uniformity in so far as the relationship is concerned between rates and services on the one hand, and, on the other, average family incomes in given states. The average family income for a given county or district could not be determined with accuracy, but the average family net incomes for the 1940 crop season for FSA borrowers in given states were used as a basis for the calculations, the results of which are set forth in Table No. 5. "Net income" means that income available to a family after farm operating expenses have been paid. It represents substantially more than the net cash income for it includes the value of products such as food and fuel produced on the farm for home consumption. If borrower participation rates for various medical services had been compared to net cash incomes, the percentages of incomes represented would have been substantially higher.

A review of Table No. 5 reveals that it would be reasonable to raise certain membership rates as the benefits of given plans are broadened. On the other hand, it is clear that family contributions will have to be supplemented as more-inclusive plans extend into certain needy areas. In this connection it must be borne in mind that since families have various legitimate medical expenditures over and above those represented by their membership fees, except in some unattained "ideal" program, it would be unfair for annual membership rates to represent the highest percentage of income which could be exacted. Moreover, program planners calculating family contribution rates in needy areas must never overlook the danger of forcing families to sacrifice other vital living standards, or neglect the possibility of intelligent subsidization when clearly indicated.

There is a tendency in certain regions to adopt flat membership rates. Even in those plans in which the rates vary with the size of family, the basis for setting the rates is in no sense an actuarial one but is rather a concession to the understandable feeling on the part of many families and physicians that the rate should be higher the more members there are in a given family. In a large number of plans there is a basic rate of $14 or $20, for example, for the farmer and his wife, with either $1 or $2 being charged for each dependent up to a certain maximum such as the rate for a family of eight or more. The membership rates listed in Table No. 5 and 6 do not take into account extra charges imposed in a few medical care units, such as an extran charge of $10 in Region I for each obstetrical case, and a small charge for the first home call in any illness in the California program.

Methods of Paying Professional Groups for Services. There is such variation in the matter of distributing funds to those rendering services that it is difficult to cite any common pattern evident

through the program as a whole. However, there are certain underlying features characteristic of the entire program. In the first place, the Farm Security Administration does not set the fees or rates to be charged by professional groups. Secondly, the review and auditing of bills is placed in the hands of committees representing the groups rendering the services.

Although not universal, there is a characteristic method of paying for the services of physicians. Ordinarily annual funds deposited by members for physicians' services are divided into equal monthly allotments. Approved bills for services in a given month are paid in full by the trustee if the allotment is sufficient. If bills cannot be paid in full, the allotment is distributed to the physicians on a pro rata basis, each physician receiving the same percentage of payment on his bills. As a rule, any monthly surpluses are held to the end of the fiscal year and applied against unpaid balances of physicians' bills, and then by agreement, bills are written off as paid in full. Some variations in this pattern may be cited: (a) there may be one pooled or common fund for office, home, and obstetrical care and another for surgical or other specialist care; (b) there may be one fund for all physicians' services, including surgical care; (c) allotments and payments may be on a quarterly rather than a monthly basis; (d) larger allotments may be provided for four or five winter months; (e) surpluses may be distributed to increase allotments for remainder of year or to increase allotments for winter months; (f) payments made throughout the year may be limited to 50 percent payment on approved bills, with the surplus distributed at the end of the year as a means of securing a more equitable distribution of the funds.

In 54 medical care groups in 55 counties, physicians are being paid on a capitation basis, i.e., in accordance with the number of families selecting them as family physicians rather than on the basis of the amount or type of service rendered each month. These units served 9332 families as of June, 1941, in Regions V, VI, IX, X, and XII. Each unit on a capitation basis is so listed in Table No. 6. In each instance, the local medical society has itself adopted this method of payment in preference to the usual type of pooled fund plan. It is still too early to judge whether this kind of plan will operate to the satisfaction of both patients and physicians and whether it will meet the family needs more adequately than plans of the other type.

Hospital bills are paid in various ways, including (a) having a separate pooled fund, with the hospitals agreeing to accept partial payment if necessary; (b) having a fund combined with the surgical care allotment, with bills being paid from the same fund for both hospitalization and surgical care; (c) having all funds for a month pooled in a single allotment, with hospital bills within certain limits being handled as preferred charges paid in full prior to further distribution of the allotment; (d) having all funds in one general allotment, but with hospi-

tals accepting the same pro rata reduction in bills as the other professional groups; (e) having the whole matter of payments to hospitals handled by an existing group hospitalization plan.

The provision of prescribed drugs has proved to be a rather perplexing matter. There is a tendency to limit drugs to U. S. Pharmacopoeia and National Formulary preparations, and to exclude unusual or expensive products such as biologicals and vitamin concentrates. Some of the ways in which payment for drugs is being handled are as follows: (a) having a pooled fund combined with the general practitioner care fund, with druggists taking the same pro rata reduction, if necessary, as the physicians, or with druggists guaranteed a certain minimum "cost plus" payment; (b) having physicians include charges for prescriptions in their bills, making their own arrangements with local druggists; (c) making drug bills preferred charges, paid in full before physicians are paid; (d) having separate pooled fund from which full or partial payment of drug bills is made.

Impact of the Program on Medical Profession. Through development of the medical care program the medical purchasing power of substantial groups of rural families has been increased, thus helping to maintain medical facilities in areas threatened by a continued diminution in such facilities. Studies of the medical care expenditures of FSA borrowers indicate that their past expenditures were uniformly lower than their current expenditures through the program.

There have been instances where physicians have moved into medically needy areas because of the organization of medical care groups of FSA borrowers. There have been other instances where physicians have been induced to hold regular office hours in localities previously without such service.

It is not known whether the development of the program has resulted in the actual organization of local medical societies, but there have been repeated instances of renewed activity in medical societies which were previously morbid if not moribund. It must be acknowledged that the somewhat controversial aspect which physicians commonly see at first in the program may have had something to do with this rejuvenation of medical societies, but whatever the primary cause, there has resulted an awakened interest in medical society action. It is not unusual for an FSA representative to encounter "the largest society meeting in years" when the FSA program is on the agenda. Not unusual was the report of a society secretary that for the first time in many years every doctor in the county had joined the society, a result which he ascribed largely to the FSA program.

It is clear that the program is playing an active part in awakening physicians to the needs of medically indigent rural families. They are learning that they have the opportunity to meet these needs and at the

same time to receive extra income from a relatively new source. They are learning, by doing, to assume their rightful responsibility toward the medical aspects of organized medical services. They have seen that they can work with a governmental agency without its trying to dominate them.

At the meeting of the American Medical Association held in Cleveland, Ohio, June 2 to 6, 1941, two reports were submitted to the House of Delegates that mentioned the medical care program of the Farm Security Administration. The report of the Committee on Legislative Activities included the following statement: "Any plan to promote improvement in the collective family health among Farm Security Administration clients should redound to the general benefit. The aid given farm families which improves their economic condition and enables them to liquidate their obligations later has a sound economic basis. If the aforementioned rehabilitation plan is developed, it should receive the approval of the component county medical society and should be accomplished through that society." The report of the Reference Committee on Legislation and Public Relations expressed "highest approval" of the "policy of arriving at understandings with constituent state medical societies," noted with pleasure the report of the rehabilitation medical work, and stated: "Any attempt to restore health and self respect to American families and to preserve individuality, independence and security is to be commended."

Review of Medical Care Activities in the Twelve Regions. In the following pages is given a review of medical care developments in each Region. Reference to separate resettlement project programs, dental care plans and the health program for migratory agricultural workers will be found elsewhere in this report. The following review relates primarily to medical care activities on behalf of FSA borrowers.

Region I

Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire New Jersey, New York, Pennsylvania, Rhode Island, Vermont

During the fiscal year ending June 30, 1941, there were no significant developments relative to working agreements or understandings with the various state medical associations in Region I. Satisfactory agreements were already in effect with the associations in the seven states in which activities were concentrated during the year. Because of the relatively small number of borrowers and the rather highly industrialized character of most of the areas involved, efforts directed toward obtaining working agreements with state medical associations were postponed in Massachusetts, Connecticut Rhode Island, and Delaware.

At the end of the previous fiscal year, there were only 4 medical care groups in operation in Region I, there being one each in New Hampshire, New Jersey, Pennsylvania, and Vermont. These 4 plans extended to 19 counties but covered only 540 families or 2746 persons.

By the end of June, 1941, 11 medical care units were in effect in Region I covering 46 counties in 5 states, the state added during the year being New York, with 3 units in 4 counties. Aside from the new plans in New York, the expansion of the program in Region I was found for the most part in New Jersey and Pennsylvania. The 11 groups included 1597 families or 7841 persons, representing an increase of 196 percent over the number of families participating the previous fiscal year.

The growth of the medical care program in Region I from the time when the first county unit was established in New Jersey is shown in the following table:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1939	June 1940	June 1941
New Hampshire		2	2
New Jersey	1	1	19
New York			4
Pennsylvania		2	7
Vermont		14	14
	1	19	46

Although it is gratifying to note the increase in participating families and in the number of counties to which the program was extended during the past fiscal year, the responsibility for more concentrated efforts in connection with the plans already organized is seen in the fact that in 46 counties covered, only 50.8 percent of the borrowers eligible for participation in the plans are actually enrolled. Moreover, in 3 of the 4 units which were operating in Region I as of June, 1940, there was a decrease in the number of families participating, representing a decrease of 12 percent in New Hampshire, 18 percent in New Jersey (Atlantic County), and 10 percent in Pennsylvania. This situation is hardly mitigated by the fact that an increase of 23 percent in the number of families participating in Vermont counterbalanced other losses, making a net increase of 10.7 percent in the number of families participating in units which were in effect both in June, 1940 and in June, 1941.

Aside from two medical care plans in New York which include hospitalization and surgical and specialist care, the various plans in effect in Region I provide general practitioner care at annual rates which ordinarily range from $16 for a couple to $20 for a family of six or more. On the basis of studies directed toward ascertaining the actual experience of the families involved, efforts are being made to extend certain plans in the region to include hospitalization and the services of surgeons and other specialists.

The form of organization in Region I is a simple trusteeship, the trustee ordinarily being a "neutral" person rather than a representative of the borrowers, the physicians or the Farm Security Administration. Committees of borrowers are being organized to serve in an advisory capacity and thoughts are being directed toward the organization of health associations to provide an opportunity for the borrowers to take a more active part in the program.

Maine. Although a working agreement was reached with the Maine Medical Association at the end of the previous fiscal year, it was possible to devote only a limited amount of time to promoting the development of a medical care program in Maine during the year. By June, 1941, certain preliminary steps had been taken toward developing a district plan providing rather comprehensive services in a six-county area centering around the city of Bangor.

Maryland. The first medical care plan to be developed in Maryland was approved toward the end of the fiscal year by county medical societies in Queen Annes, Caroline and Kent Counties. This plan, which was to include general practitioner care and prescribed drugs, was expected to begin operations on July 1, 1941.

New Hampshire. The district plan which had been in effect in Grafton and Cheshire Counties since January, 1940, ended the fiscal year with a 12 percent loss of membership. The number of families participating was

only 41 percent of the total number of borrowers eligible in the two counties. Steps necessary to improve this situation were being studied at the end of the fiscal year.

The Coos County Medical Society, in April, 1941, approved the development of a plan which would be an independent unit. It was not yet in operation at the end of the fiscal year.

New Jersey. The Medical Service Administration of New Jersey is administering a statewide plan for Farm Security Administration borrowers which represents an expansion of the general practitioner care plan in effect previously in Atlantic County. This plan, which is based on annual participation rates of from $16 for a couple to $20 for a family of 6 or more, went into operation on May 1, 1941. At the end of the fiscal year, 397 families were enrolled in the plan, representing 19 of the 21 counties in the State. Only 43 percent of all families eligible were enrolled.

New York. The first units organized in New York State commenced operations during the past fiscal year, 2 units covering 3 counties having started in July, 1940, and the third in April, 1941. Two of these units (Washington and Chenango Counties) in addition to general practitioner care include hospitalization and surgical and specialist care limited to acute conditions. The hospitalization plan in effect in Washington County is based on an annual rate of $10 per family for 14 days' ward care per person, with a limit of 28 days per family. In this plan, approved hospital bills were paid in full at charges which averaged about $4 per patient-day and a small surplus was available at the end of the year to serve as a reserve fund for the following year.

Another type of hospitalization plan is in effect in Chenango County. The borrowers have joined the hospitalization plan in the area which has an annual family rate for ward care of $10.92, covering 18 days per person. In this plan, administered by Hospital Plan, Inc., dependents other than young children must pay an additional $1 per day when hospitalized.

At the end of the fiscal year a program was being developed in the western part of New York which might be administered by Western New York Medical Plan, Inc.. Approval of this plan had already been secured from 4 of the 6 county medical societies concerned. Another plan in New York, that in St. Lawrence County, had also been approved and it was expected to start operations on July 1.

Pennsylvania. Fairly satisfactory progress was made in Pennsylvania during the fiscal year, there being an increase from one plan in 2 counties to 5 plans covering 7 counties. Although these plans differ somewhat in detail, they all provide general practitioner care at rates ranging from $16 to $20 per family. As of June 30, 1941, 390 families

were enrolled in these plans, representing 55 percent of the borrower families eligible.

At the end of the year the medical societies in two other counties had approved plans to begin operation by September 1, 1941, and negotiations were in progress with two other medical societies. The aim was to extend the program to approximately 30 additional counties during the coming fiscal year.

Vermont. The 14-county statewide program in Vermont completed its second year of operation on June 30, 1941. Although there had been an increase of 23 percent in the number of participating families during the fiscal year, the number enrolled at the end of the year represented only 51 percent of the total number of families eligible.

It was expected that during the coming fiscal year steps would be taken to add hospitalization and surgical and other specialist care to the services available through the plan, thus increasing its effectiveness as a source of protection to the families enrolled.

Region II

Michigan, Minnesota, Wisconsin

Although several dental care plans were in effect in Michigan and Wisconsin by June, 1941, there were no medical care plans in actual operation in either of these states or in Minnesota. Nevertheless, definite progress had been made during the fiscal year and the approval of the medical profession had been secured for the establishment of plans for borrower families in Michigan and Minnesota.

Michigan. Negotiations with the Michigan State Medical Society had been undertaken first in 1938, but no definite working agreement was secured until the past fiscal year. This long delay was due to activities of the Society directed toward setting up a statewide pre-payment plan for low income groups. Pending the organization of such a plan, the State Medical Society had been unwilling to cooperate in organizing plans to meet the special needs of FSA borrowers. After enabling legislation was secured, the Michigan Medical Service, Inc., was organized in 1939, and shortly thereafter it offered a prepayment plan providing physicians' services to families with gross incomes of $2,500 or less, at an annual rate of $54 for a family of average size. Since this plan was based on participation rates well beyond the ability of FSA borrowers to pay, negotiations during the past fiscal year were directed toward securing the cooperation of the Michigan Medical Service in administering a special program for FSA borrowers at a rate commensurate with their average incomes.

In October, 1940, the Michigan State Medical Society approved the negotiations between the FSA and the Michigan Medical Service which finally resulted in a specific agreement in May, 1941. At that time, the Board of Directors of the Michigan Medical Service approved a plan to be put into effect on a trial basis in one county, the thought being that it might be extended to other counties as soon as the original plan had proved reasonably sound. The plan offered was similar to the regular $54 plan but was to be made available to FSA borrowers at an annual rate of $26.50 per family. The plan is to cover medical and surgical care in the office, home and hospital, including services rendered by such specialists as radiologists and pathologists. Obstetrical benefits are excluded during the first year of participation of any family. In general, the services are limited to care in acute conditions but upon the recommendation of any physician a case with some chronic or pre-existing condition may be reviewed by the Medical Advisory Board when it is felt that the health of the patient is seriously affected or the rehabilitation of the family retarded. It is understood that the Medical Advisory Board will be liberal in approving corrective treatment for such cases.

At the end of the fiscal year, an effort was being made to organize this plan on a trial basis in one county in the state. Once the plan proved successful the objective was to extend it to at least one county in each FSA district before the end of the next fiscal year. Another aim for the coming year was to find some solution to the problem of providing hospitalization at a cost within the ability of the families to pay. It was expected that there would be further negotiations with the Michigan Society for Group Hospitalization although the Society had taken the position in the past that it could not consider sponsoring a plan which would cost less than its regular $18 rate.

Minnesota. Following a period of intermittent negotiations with the Minnesota State Medical Association, extending back to 1938, the Association in February, 1941, approved the establishment of medical care plans for borrower families to be on a trial basis in three counties. By the end of the fiscal year, the Morrison and Otter Tail County Medical Societies had approved a plan providing physicians' services and surgical care for acute conditions at an annual rate of $23 per family. Approximately 250 families had signed participation agreements for these two plans which were expected to start operations on August 1. If these plans proved successful, the State Medical Association agreed that permission would be extended to FSA representatives to approach other county medical societies throughout the state.

Wisconsin. The only understanding with the State Medical Society of Wisconsin is that extending back to January, 1938, which provided that the various county medical societies would cooperate in setting fees for the borrowers at the level of the FERA fee schedule. The State Society has been unwilling in the past to agree to plans based on the insurance principle and during the past fiscal year there were no particular negotiations with the State Society for the purpose of effecting a more

satisfactory agreement. It was recognized in Region II that it would be helpful in connection with the negotiations in Wisconsin, as well as in other states, if a full-time regional medical officer might be employed. At the end of the fiscal year there was provision in the regional budget for such assistance, and it was expected that a regional medical officer would be on duty during the coming fiscal year.

Pending the securing of an agreement with the State Medical Society, the FSA borrowers in Oconto County were approached toward the end of the fiscal year with reference to their possible interest in taking part in a medical care plan. The interest among the families was such that the enrollment of 118 families was secured without delay. Representatives of these families approached the County Medical Society just before the end of the fiscal year, and the society agreed to take up the matter at a meeting to be held in July.

Region III

Illinois, Indiana, Iowa, Missouri, Ohio

The thorough organizational work which has been emphasized in Region III resulted in healthy growth of the medical care program during the fiscal year 1940-41, particularly in Missouri and Ohio. There is evidence that Farm Security Administration personnel from the regional and state levels to the district and county levels have become better informed concerning the program and that they are not only interested in it but are cooperating actively in its promotion. Doubtless the expansion of the program has been aided by the adoption of uniform policies and the formulation of a uniform plan of operation which is used throughout the region.

During the fiscal year there was general improvement in relationships with the various state medical associations. The original agreements between the Farm Security Administration and these associations were strengthened during the year, particularly in Missouri.

The number of medical care groups in Region III, the number of counties covered, and the number of families participating were all more than doubled during the past year. In June, 1940, 53 units were in operation in 55 counties in the 5 states, and these plans covered 2766 families or 13,064 persons. As of June, 1941, there had been an increase to 111 different units in 116 counties, covering 7519 families or 36,499 persons. There was an increase of 172 percent in the number of participating families. These figures represent net increases, taking into account the fact that 7 county units were terminated during the year. Although the membership of the medical care units which were in operation both in June, 1940 and in June, 1941 increased by 33 percent, the total

number of families participating in all of the units in the region in June, 1941 represented only 38.6 percent of the families eligible to participate in the areas involed.

The following table shows not only those states in which the greatest expansion took place during the past year, but gives a general picture of the growth of the program in Region III from its beginning in 1937:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1937	June 1938	June 1939	June 1940	June 1941
Illinois				5	10
Indiana			5	4	6
Iowa	1	2	3	1	3
Missouri		2	12	28	56
Ohio		1	11	17	41
	1	5	31	55	116

With very few exceptions, a uniform plan is being put into effect in Region III which provides physicians' services including the services of surgeons and other specialists. Although surgical work is confined largely to the treatment of acute conditions, corrective surgery falls within the benefits of many of the plans when a given condition threatens the health or rehabilitation of the individual concerned. In general, there is a flat annual charge of $23 per family for these services, with $16 being allocated for physicians' care, $6 for surgeons' services and $1 for administrative expenses. In a few counties, $23 is the maximum rate, with slightly lower rates for small families.

The trusteeship form of organization is followed, with a committee of three physicians to supervise medical aspects of the plan, and with a governing body of from five to seven borrowers elected by the membership to represent different areas in the county. A trustee is appointed by the governing body of borrowers, subject to the approval of the physicians' committee and the local representatives of the Farm Security Administration.

In the Annual Report for the fiscal year 1939-40 it was noted that there were only 8 county units still on the basis of individual participation which was once characteristic of Region III plans. This number had dwindled by June, 1941 to only 5 such plans, 3 in Missouri and 2 in Ohio. The process of converting plans of the individual type to plans based on the insurance principle has thus been almost completed..

Illinois. Despite the termination of one county program in Illinois during the fiscal year, there was a net increase from 5 county units to 9 units in 10 counties. There was an increase of 76 percent in the number of participating families, 643 being enrolled as of June, 1941. The active organization of medical care units was in process at the end of the year in 26 additional counties.

Indiana. Relatively little progress was made in Indiana during the fiscal year, there being an increase from 3 units in 4 counties to 5 units in 6 counties, with 207 families enrolled as of June, 1941, representing 29 percent of the families eligible in the 6 counties. It is encouraging to record the fact, however, that 46 additional county units were in the process of being organized at the end of the year.

Iowa. At the end of the previous fiscal year there was only one plan in operation in Iowa, and as of June, 1941, there were 3 plans in effect covering 335 families. These 3 plans taken together have the highest percentage of eligible families enrolled of any state in the region, namely, 59 percent. However, the one plan which operated throughout the year showed only a 3 percent gain in membership.

Missouri. A very good working relationship has been established between representatives of the Farm Security Administration and the Missouri State Medical Association. As an example, representatives of the State Medical Association have agreed to attend meetings of medical societies at the request of the Farm Security Administration in cases where there is apparent misunderstanding of the program on the part of physicians in local societies. This spirit of active cooperation is one of the factors accounting for expansion of the program in Missouri from 27 medical care units in 28 counties to 54 units in 56 counties. As of June, 1941, 3492 families were enrolled in the various units, representing a net increase of 171 percent over the previous year. This takes into account the loss of 6 county units terminated during the year.

Even though there has been satisfactory growth in the number of medical care units in Missouri, there is a serious problem to be faced relative to the number of families actually enrolled in the areas to which the program extends. Only 32 percent of the total number of eligible families were enrolled as of June, 1941.

A promising development for the coming fiscal year is the prospective development of a 7-county program in Southeast Missouri which would include rather comprehensive health services. The general plan is to charge families at an annual rate of $42 for the ordinary services being developed or under consideration for early development in the region. These services would include physicians' care at $16, surgeons' care at $6, hospitalization at $8, limited dental care at $6, prescribed drugs at $5, and the remaining $1 for administrative expenses. In addition, it is contemplated that the program would provide for the correction of certain chronic conditions over a period of time at an annual cost of $7 per family for certain types of corrective work, and $2 per family for eye glasses. A dental trailer would operate in the area and a public health nurse would be employed by the proposed association to serve in each county. There would also

be direct financial support of a laboratory to be administered by the State Health Department. These various services would cost an average of $16.65 per family in addition to the $42 referred to, or a total of $58.65 per family. This program, which is designed to meet the needs of over 4000 FSA families of various categories in the area, would have to be rather heavily subsidized at first. All families able to do so would be requested to pay $42 toward the total cost, or as large a portion of the $42 as possible.

Ohio. Substantial progress was made in Ohio during the fiscal year, there being an increase from 17 county units to a total of 40 units in 41 counties. The number of families increased by 205 percent to a total of 2842 families enrolled as of June, 1941. That further expansion of the program is imminent is seen in the fact that 30 additional county units were in the process of organization at the end of the year. If the objective of organizing plans in these counties is attained in the coming fiscal year, it will mean that the program has been extended to 71 out of a total of 88 counties in the state.

Region IV

Kentucky, North Carolina, Tennessee, Virginia, West Virginia

Recently the understanding with the Kentucky State Medical Association was broadened to cover plans providing surgical care and hospitalization as well as general practitioner care. At the end of the fiscal year there was a foundation of satisfactory working agreements with all five state medical associations in Region IV. Moreover, local professional groups were, with few exceptions, proving to be very cooperative.

During the year there was an increase in Region IV from 61 medical care units in 84 counties to 77 units in 102 counties. There was a 55 percent increase in the number of participating families, bringing the total number of member families up to 7912--over 45,000 persons. These gains were made despite the termination of 8 units covering 17 counties, a lapse in activity which was felt to be only temporary in most instances. Gains during the year can be measured only partially by the figures given, for as of the end of June various county medical societies in all five states had approved units to go into operation in 32 counties early in the following fiscal year.

The chief causes underlying the termination of 8 units in Region IV illustrate rather graphically some of the problems faced. They may be summarized as follows: Plan A--misunderstanding over provision of drugs; physicians paid for drugs they prescribed, and not enough money left to satisfy physicians. Plan B--physicians wanted 100 percent

payment. Plan C--physicians collected fees on the side and the plan was suspended by FSA action. Plan D--review committee of physicians "approved any and all bills presented"; also some abuse by families. Plan E--physicians skeptical from the start and did not give plan fair trial. Plan F--unit dwindled and finally was suspended due to apathy on part of local FSA personnel using the excuse that the families were unable to pay the cost. Plan G--a district plan too loosely organized, without local responsibility; defense activities keeping physicians busy in other than rural areas. Plan H--the only physician in the rural area called to military service.

The following table shows how the Region IV program has developed since the fiscal year 1938-1939:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1939	June 1940	June 1941
Kentucky		4	3
North Carolina	10	35	38
Tennessee	7	10	20
Virginia	8	28	34
West Virginia		7	7
	25	84	102

Counting the number of counties to which the program has been extended does not give the measure of the extent to which needs are being met. The number of participating families in Region IV could be more than doubled within the 102 counties in which plans are already operating.

In Region IV there are trusteeships rather than associations of borrowers. In general, there is a separate allotment of funds for each type of service; for example, an allotment for general practitioner care and other allotments for surgical care and for hospitalization when these services are included in the plan. Advisory committees of borrowers have been elected at group meetings in certain counties, but these committees are not yet as active as would be desirable.

Kentucky. The chief activity in Kentucky during the year was that of working with both the Farm Security Administration personnel and the medical profession on the preliminary ground work essential to the expansion of the program. Although only 3 county units covering 277 families were operating in June, medical society approval had been secured for 14 additional units to be started early the following fiscal year.

North Carolina. Because of the suspension of units in 6 counties, believed to be temporary, there was a net gain of only 3 counties during the year. However, there was a net increase of over 10,000 persons,

bringing the enrollment up to 59 percent of the families eligible in the counties organized.

Almost all of the North Carolina plans are confined to general practitioner care. Hospitalization is handled for the most part on an individual case basis through the cooperation of county welfare departments. The local welfare agency certifies that a given case is entitled to welfare rates, ordinarily about $2 per day, and in such instances there is no charge for medical or surgical services provided in the hospitals.

Tennessee. The greatest expansion of the program in the region was recorded in Tennessee, with a net increase from 8 units in 10 counties to 17 units in 20 counties. There was an increase of 166 percent in the number of participating families. At the end of the year 7 additional county units were ready to commence operations. Activities in Tennessee have taken a new lease on life with the new state FSA policy that provision be made for medical care participation in all new farm and home plans and that additional efforts be directed toward enrolling old borrowers through group meetings.

Virginia. Despite the suspension of the 9-county district plan in Southwest Virginia, there was a net gain during the year from 13 medical care units in 28 counties to 17 units in 34 counties, with 1359 families enrolled as of June, 1941. The chief reasons underlying the suspension of the district plan were cited above in the reference to "Plan G".

The chief problem faced in Virginia is that of inadequate enrollment of families in the areas to which the program has been extended. The number of enrolled families represents only 33 percent of those eligible. Moreover, there was a decrease of 12.5 percent in the number of families participating in the 11 units which were operating both in June, 1940 and in June, 1941.

West Virginia. As of June, 1941, the only units operating in West Virginia were the 7 county units which had been started in the spring of 1940, but 7 additional plans had been approved by medical societies to go into operation early in the next fiscal year.

The same difficulty encountered in Virginia, that of enrolling a substantial proportion of the borrowers, is found in West Virginia. Even though there was in increase of 78 percent in the number of participating families during the past year, there was still only 32 percent participation at the end of the year based on the total number of eligible families.

Region V

Alabama, Florida, Georgia, South Carolina

The past fiscal year has seen the continuation in Region V of the previous year's period of consolidation, with slower expansion of the program than in 1938-39 when there were such rapid developments. There was an increase during the year from 162 medical care groups in 164 counties to 181 groups in 187 counties. There was a 13 percent net increase in the total number of families enrolled, with 33,285 families - over 180,000 persons - taking part as of June, 1941. Most of the expansion took place in Alabama and Georgia, there being an increase of almost 3,000 families in Alabama and more than 1,000 families in Georgia. Only 6 county units were terminated during the fiscal year, a "morality" of less than 4 percent. A number of the units which had been terminated during previous periods were reinstituted.

Growth of the program in Region V from the organization of the unit in Harris County, Georgia, in March, 1936, is illustrated in the following table:

No. of Counties with Medical Care Groups of FSA Borrowers

	June '36	June '37	June '38	June '39	June '40	June '41
Alabama			3	23	23	40
Florida				5	5	6
Georgia	1	2	3	108	108	121
S. Carolina				17	18	20
	1	2	6	153	164	187

The record which Region V has made in enrolling a large proportion of eligible families is outstanding. As of June, 1941, the enrollment stood at 84 percent of the total number of families eligible in the counties to which the program extended. This favorable situation is the direct result of the regional policy relative to including an appropriate amount for medical care participation in farm and home plans. Participation in the medical care program is not compulsory but when funds for participation are set up in a family's plan, there is more than ordinary inducement to the family to become enrolled.

In those medical care groups which were operating both in June, 1940 and in June, 1941, for which complete reports are available, there was an average increase of 4.7 percent in the number of families enrolled. An increase of 16 percent in Alabama saved the region as a whole from a rather poor record with respect to these plans which operated throughout the year for there was a decrease of 1 percent in the number of families in Georgia units, a decrease of 10 percent in the South Carolina units, and a decrease of 13 percent in the number of enrolled families in the Florida units.

Almost 90 percent of the families enrolled in Region V are in medical care groups which have limited hospitalization and surgical care benefits as well as general practitioner care. Provision for ordinary drugs is made in about 80 percent of the units in the region. The average annual participation rates are about $17 per family in Alabama and about $15 per family in Florida, Georgia and South Carolina. The usual method of allocating funds is to set aside 20 percent of the total annual funds deposited by the families in an account from which payment is made for emergency hospitalization cases. From this account, payments are made both to hospitals and to surgeons insofar as funds are available. As a rule, 80 percent of the total funds deposited is allocated for general practitioner care and the provision of ordinary drugs.

There has been an interesting increase in the number of medical care units in which physicians are paid on a capitation basis. In plans of this type, the physicians are paid in accordance with the number of families utilizing their services as family physicians, rather than in accordance with the number of items of service rendered. The number of units on a capitation basis in Region V increased from 6 the previous year to a total of 26 in Alabama, Georgia and South Carolina as of June, 1941. As a rule, the capitation fee paid to the physicians covers both general practitioner care and ordinary drugs. The two most prevalent methods of handling the provision of drugs under the capitation plan are for the physicians to dispense drugs themselves and for the physicians to make arrangements with local druggists whereby the druggists are reimbursed by the physicians for the drugs prescribed. Several county units discontinued in previous periods have been reinstituted by having them change over to the capitation plan.

The form of organization of medical care units in Region V is that of simple trusteeships. The need for more active family participation in the activities of the units is acknowledged.

Alabama. There was an increase from 33 county units to 40 during the fiscal year, with a 25 percent increase in the number of families enrolled. Only 2 county units were terminated during the period, and the experience relative to reinstituting suspended plans has always been good in this State. Alabama is the only state in the region in which there was an increase in the number of enrolled families in those units which were operating both in 1940 and in 1941, there being an increase of 16 percent, bringing the proportion of those enrolled up to 90 percent of the families eligible in the counties covered.

Every medical care group in Alabama provides limited hospitalization and emergency surgical care as well as general practitioner care and drugs. The rates are somewhat higher than they are in other states in the region, averaging anout $17 per family. At the end of the year there were 8 units on a capitation basis, a natural spread of this type of plan from its focus in Wilcox County.

Florida. Difficulties are still being encountered in expanding the program in Florida. At the end of the previous fiscal year 5 county units were in operation, and with 2 county units being terminated during the year and other counties added, there were 4 units in 6 counties operating in June, 1941. Only 320 families were enrolled in these groups, representing a decrease of 44 percent from the number of families enrolled the previous year. In the 3 groups which operated both in June, 1940 and in June, 1941, for which records are available, there was a 13 percent decrease in the number of participating families.

Georgia. There was further growth of the program in Georgia during the year, with an increase from 106 units in 108 counties to 117 units in 121 counties. There was a net increase of 7.6 percent in the number of families enrolled, bringing the total number up to over 15,000. Only one group was suspended during the year, and this took place in a county in which only one physician is located.

There are 13 medical care groups in Georgia on a capitation basis, some of them representing units which had previously operated in a very unsatisfactory manner on a fee-for-service basis.

South Carolina. Although the number of county units in South Carolina increased from 18 to 20 during the past year, there was a slight decrease in the total number of families enrolled. In those units which operated throughout the year there was a 10.1 percent loss in the number of participating families. As of June, 1941, 5 additional county medical societies had approved plans which were to go into operation early the following year.

In two counties in South Carolina in which there has been a delay in arranging for physicians' services on a prepayment basis, an interesting plan has been developed to cover emergency hospitalization and surgery. In one of these counties the families pool $5 each, and in the other $3 each, creating a special fund from which payments are made when catastrophic illnesses occur. It is felt in the region that this type of plan may reduce the necessity for direct financial assistance to families pending the development of more complete plans and that it may be easier to institute plans of the ordinary type once these limited arrangements have proved their worth.

Region VI

Arkansas, Louisiana, Mississippi

As in 1939-40 there was definite expansion of the medical care program in Louisiana, with Mississippi sharing the honors during the past year. There was evidence of more general acceptance of the program on the part of the medical profession in these two states and in Arkansas.

In Region VI as a whole, there was a net increase during the fiscal year from 130 units in 131 counties to 146 units in 148 counties. The program was thus extended to two-thirds of the 221 counties in the region. Moreover, there was a net increase of 48% in the number of families covered, with a total of 29,372 families or about 150,000 persons enrolled in the program as of June, 1941. These families represented 67 percent of all families eligible in the counties in which units have been organized.

These gains were made in Region VI despite the fact that 13 county units, or 10 percent of all units operating in June, 1940, were suspended during the past fiscal year. The factors underlying the suspension of these units include the following: (a) disagreeing factions in medical society; (b) indifference of physicians toward program; (c) physicians concentrated in the towns, or too few physicians in the county, with borrowers widely scattered in the rural areas; (d) disagreement between physicians and druggists; (e) failure of FSA personnel to set up participation funds in family budgets; (f) refusal of physicians to accept Tenant Purchase families on the program.

Region VI includes some of the oldest plans organized for FSA borrowers in the United States. With Region V, it has certain plans which commenced operations in 1936. The following table shows the expansion of the program in the region from its beginning:

No. of Counties with Medical Care Groups of FSA Borrowers

	June '36	June '37	June '38	June '39	June '40	June '41
Arkansas	5	14	56	67	68	59
Louisiana	-	-	1	7	21	30
Mississippi	2	3	3	38	42	59
	7	17	60	112	131	148

It is usually a healthy sign when medical care groups gain in membership. Region VI has an excellent record in this respect. In those groups which were operating both in June, 1940 and in June, 1941, there was a 30 percent increase in the number of enrolled families, bringing the total in these units up to 66.7 percent of the families eligible in the areas concerned.

Various combinations of services are offered in the plans in Region VI. In general, the services in Arkansas include limited hospitalization and emergency surgical care as well as general practitioner care. As a rule, 80 percent of total funds is set aside to pay family physicians for their services and the remaining 20 percent constitutes a separate fund from which payments are made insofar as it is possible for hospitalized cases.

The provision of drugs has been eliminated for the most part from the Arkansas program. In many instances additional small loans are made to the families to enable them to pay for drugs on an individual basis. In most of the units in Louisiana and Mississippi provision for hospitalization is omitted because of the availability of Charity Hospitals in Louisiana and because of state appropriations for hospitalization of the medically indigent in Mississippi. The latter arrangement is rather unsatisfactory and it is expected that eventually provision will be made for hospitalized cases in the Mississippi plans.

Almost all of the units in Arkansas are organized as unincorporated health associations. In Louisiana there are trusteeships and in Mississippi there tend to be associations in most of the older plans and trusteeships in those units organized recently. Whatever the form of organization, an effort is being made to see that the borrowers have representation either on boards of directors of the associations or on advisory committees in the case of the trusteeships. These boards or committees usually include from 3 to 7 borrowers chosen by the families either in county-wide or in neighborhood meetings. One of the chief functions of these committees is that of appointing trustees. It is recognized that neither the boards of directors nor the advisory committees are as active as would be desirable, and more stress is being laid on group action.

Arkansas. Although there was a decrease from 68 county units to 60 separate units in 59 counties, the groups in 9 counties having been suspended, nevertheless there was a net increase in the number of enrolled families in Arkansas with 11,624 families or 57,214 persons being enrolled at the end of June. This represented an increase of 6.5 percent in the total number of participating families, and the June total represented 65.6 percent of all families eligible in the counties concerned. Moreover, there was an increase of 14.3 percent in the number of families in units which were operating both in June, 1940 and in June, 1941.

At the end of the fiscal year efforts were being directed toward solving the problem of providing hospitalization. The State Hospital Association had agreed to appoint a committee to work with the Farm Security Administration in developing a mutually satisfactory program. The group hospitalization organization in Arkansas had shown considerable interest in developing a special plan based on annual payments of $12 per family. It was possible that during the coming year a somewhat more adequate arrangement for hospitalization than that existing in the past would be tried on an experimental basis in the county units, with families paying from $5 to $7 annually for certain limited benefits.

As of June, 1941, two county units in Arkansas were paying physicians on a capitation basis. Representatives of the State Medical Society, while not approving plans on this basis, had given permission for such plans to be developed upon the request of the county medical societies.

Louisiana. There was an increase of 111.5% in the number of participating families in Louisiana, with growth of the program from 21 to 30 parish units. The 6,046 families enrolled at the end of the year constituted 55.9 percent of all eligible families in the parishes concerned. A healthy sign of growth was an increase of 60.9 percent in the number of enrolled families in the 21 units which operated throughout the year.

Mississippi. With the renewed basis for a working understanding with the medical profession in Mississippi, there was again substantial spread of the program in the State with an increase during the fiscal year from 41 medical care groups in 42 counties to 56 groups in 59 counties. Even though units in 4 counties were suspended during the year, there was a 92 percent increase in the total number of families enrolled, with 11,702 families and over 60,000 persons actively participating as of June, 1941. In the 36 counties for which records are available in which units were operating throughout the fiscal year, there was a 42.5 percent increase in the number of families enrolled, bringing the total enrollment up to 74.6 percent of those eligible in the counties covered.

It is of considerable interest that a majority of physicians in the Mississippi counties in which medical care units have been organized are said to prefer payment on a capitation basis. Almost all of the new plans being organized are being set up on a capitation basis and a number of the older plans are changing over from common fund or "pool" plans to capitation plans.

Region VII

Kansas (80 counties), Nebraska, North Dakota, South Dakota

Perhaps the most significant development in the medical care program in Region VII during the past fiscal year was the initiation of a large district unit in South Dakota, signalizing the renewal of a close working relationship with the medical profession in South Dakota after a lapse of almost two years. There was also evidence of progress in Kansas and Nebraska and some groundwork was accomplished in North Dakota preparatory to renewing medical care activities there on a district or county basis.

In June, 1940, there had been 42 medical care units operating in 48 counties in Nebraska and in the Region VII part of Kansas (which covers 80 counties). As of June, 1941, there were 53 units in operation in 85 counties in Kansas, Nebraska and South Dakota. The net loss in the number of participating families both in Kansas and in Nebraska was just counterbalanced by the addition of the 14-county district unit in South Dakota, making a net increase for the region of only 0.9 percent

in the number of families enrolled. The 7479 families in the various units at the end of the year represented 55.6 percent of the families eligible in the areas concerned.

For those units which operated both in June, 1940 and in June, 1941, there was a loss of 1151 families, representing a decrease of 15.7 percent. This loss of families and the relatively low percentage of participation was acknowledged to constitute a serious threat to the continuation of the program in some counties in the region. The following table illustrates the status of the medical care program in Region VII from the time when the statewide plans were operating in North and South Dakota.

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1937	June 1938	June 1939	June 1940	June 1941
Kansas				20	28
Nebraska				28	43
North Dakota	53	53	53		
South Dakota	69	69	69		14
	122	122	122	48	85

The best record of any region has been made by Region VII with respect to providing broad coverage for families enrolling in the medical care program. Although it must be recognized that certain of the services offered are limited in scope, the fact is that every enrolled family in the region is entitled to benefits which include general practitioner care, emergency surgical care, limited hospitalization, and at least emergency extractions in the field of dental care. Moreover, 95.7 percent of all families enrolled are entitled to the provision of ordinary prescribed drugs. These various services are ordinarily provided at an annual charge of $30 per family. Negotiations with hospitals and druggists are left up to the local medical societies and the bills for hospitalization and prescribed drugs are paid in full as preferred charges at the negotiated rates arranged by the physicians.

An interesting innovation has been an increase in membership dues to $33 per family in some units with the increase being based on adding certain services. The additional benefits are either certain preventive procedures, such as desirable immunizations or, as in some units, $4 of the $33 family deposit is set aside for a limited plan of dental care. According to the latter plan, $4 from each family constitutes a separate pooled fund from which payments are made for extractions, and for fillings and prophylaxis for children under seventeen. In this plan, a committee of dentists supervises the dental aspect of the general program and members go directly to their dentists rather than being referred for dental services by their family physicians.

In several units the physicians are setting aside a certain proportion of each monthly allotment to be used as a special fund to reimburse individual physicians when there is an especially heavy load of illness in any one community during the month. It is still too early to evaluate this development, although it has proved of direct benefit where it has been tried. It is recognized in the region that the proper administration of a special fund of this type requires an impartial and effective auditing committee of physicians.

The form of organization in Region VII is that of the informal unincorporated "medical aid association", with a treasurer or trustee. Each association has a board of directors composed of three borrowers and two representatives of the Farm Security Administration. As a rule, there is at least one ex officio member, ordinarily a physician. In most units there is a grievance committee composed of two borrowers, two physicians and the local FSA RR Supervisor.

In many of the medical care units in the region a few non-client low income farmers have been permitted to participate, not at the request of the Farm Security Administration, but upon the request of the medical societies. As of June, 1941, there were 300 non-borrower families enrolled in various units in the region.

Kansas. Although there was an increase from 20 county units to 24 units in 28 counties of the 80 counties in the Region VII part of Kansas, there was a decrease of 11.2 percent in the number of enrolled families. The 2970 families participating in June, 1941, represented 57 percent of those eligible in the counties concerned. There was a decrease of 17 percent in the number of families enrolled in those units which operated throughout the year, reducing the percentage enrollment of those eligible to 59.2 percent. At the end of the year, medical societies in 6 additional counties had approved units which would go into operation early the next fiscal year.

Nebraska. There was an increase from 22 units in 28 counties to 28 units in 43 counties during the fiscal year, but there was a net loss of 1.4 percent in the number of families enrolled. The 4008 families participating in June, 1941, represented 55 percent of those eligible in the counties covered. In those units which operated throughout the year, there was a decrease of 14.6 percent in the number of enrolled families, lowering the percentage enrollment to 58.5 percent of those eligible. As of the end of the fiscal year medical societies in four additional counties had approved units which were expected to go into operation soon.

North Dakota. After there had been a lapse of approximately a year in the medical program for borrowers in North Dakota, the State Medical Association in the spring of 1940 gave permission to FSA representatives to approach local medical societies throughout the State. The understanding at that time was that any new plans would be set up on a

district or county basis and that any plan agreed upon by a local medical society would be submitted to the Executive Committee of the State Medical Association for review and approval. During the past fiscal year, an approach was made to certain local medical societies in the State and as of June, 1941, the physicians in Grant and Wells Counties had agreed to the establishment of medical care units, provided they secured the approval of the State Medical Association.

South Dakota. Through an agreement with the Inter-Allied Professional Council of South Dakota, regional FSA representatives secured the approval of the Pierre District Medical Society for the organization of the Pierre District Medical Aid Association which commenced activities on April 1, 1941. By the end of June, the number of families enrolled in the Association had increased from 300 to 501 families or 2304 persons, representing 53 percent of the families eligible in the district. The plan adopted is similar to the more recent plans in Kansas and Nebraska, with the families paying $33 annually for the broad coverage characteristic of plans in the region.

Prior to the end of the fiscal year the Mitchell District Medical Society approved organization of the South Central District Medical Aid Association which is to include borrowers from 13 counties and will be set up at the same $33 rate as that in effect in the Pierre District Association.

Region VIII

Oklahoma (74 counties), Texas (207 counties)

Little progress was made in organizing new plans to go into effect during the past fiscal year in Region VIII, but approval was secured for 21 county units to go into operation early the following year. Many factors account for the slow progress in the region, but they might be summarized by stating that district and county FSA personnel have not yet assumed their proper responsibility for plans already placed in operation and for the development of new plans.

There has been more difficulty in securing accurate reports from the field in Region VIII than in the other regions, and the figures given in this report may be subject to slight modification. According to the records available, there was a decrease during the fiscal year from 50 units in 52 counties to 48 units in 49 counties. There was a net increase of 3.5 percent in the number of enrolled families, with the 5865 families enrolled as of June, 1941, representing 49.6 percent of those eligible in the counties concerned.

Seven county units had been terminated during the year in Oklahoma and Texas and the organization of new units did not counterbalance these

losses. The factors underlying the suspension of these 7 units include the following: (a) Lack of interest on the part of FSA personnel, (b) small caseload, (c) friction among physicians, (d) opinion of physicians that more money available through individual grants, (e) proprietary hospital "wanted the FSA to make up deficits."

According to available data, the status of the program in Region VIII for the past four years is illustrated by the following table:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
Oklahoma	4	11	23	22
Texas		8	29	27
	4	19	52	49

There is a wide variety in the combinations of services offered in Region VIII plans. In general, there is rather broad coverage with an attempt being made to furnish limited hospitalization and emergency surgical care as well as general practitioner care and ordinary drugs. In a few plans, certain limited dental services are included.

Health Associations constitute the usual form of organization in Region VIII. These associations have boards of directors composed of three borrowers elected as representatives of the families and two FSA representatives. The borrower members of these boards have proved very effective in handling abuses by enrolled families. The active participation of families in the operation of the various units is being stressed throughout the region. In a few counties the borrowers on the boards of directors have met with the committees of physicians, a development which it is hoped may spread both in the region and to other regions.

Oklahoma. The organization of two new medical care units was not enough to balance the suspension of three units and consequently there was a decrease from 23 county units in 1940 to 22 county units in June, 1941, in the 74 counties in Oklahoma included in Region VIII. In those units which operated throughout the fiscal year there was a 21 percent increase in the number of families enrolled, accounting largely for a net increase of 19 percent in the total number of families enrolled throughout the region. The 3283 families belonging to the health associations in June, 1941, represented 47 percent of those eligible in the 22 counties covered.

At the end of the year, plans had been completed for starting new units in 5 additional counties in Oklahoma. Once these county units were in operation it would leave 47 more counties to which the program could be extended in the future.

Texas. Although there has been a working agreement with the State Medical Association of Texas since January, 1938, steps were being taken at the end of the fiscal year to clarify this agreement, bringing it up to date with current developments.

In the Region VIII part of Texas (covering 207 counties), according to available reports, there was some decrease in the extent of the program during the fiscal year, with the 27 units in 29 counties in 1940 dropping to 26 units in 27 counties in June, 1941. There was an 11.1 percent decrease in the number of families enrolled, with the 2582 families taking part in June, 1941 representing 46.4 percent of families eligible in the areas concerned. In those units for which records are available, which operated throughout the fiscal year, there was a 12.4 percent decrease in the number of enrolled families, reducing the percentage of enrollment to 53.5 percent of the families eligible. During the twelve-month period, 4 county units were suspended but it was almost certain that 3 of them would be reinstituted once certain readjustments had been made.

Substantial expansion of the program in Texas was expected early in the following fiscal year for plans had been completed for the program to extend to 16 additional counties. This would still leave 164 counties not covered in the Region VIII part of Texas.

Region IX

Arizona, California, Nevada, Utah

The medical care program for FSA borrowers was extended to California for the first time during the past fiscal year and preparations were almost completed for initiating the first medical care unit to be developed in Arizona. Moreover, there was substantial progress in extending the program into new counties in Utah.

As of June, 1940, the only medical care units for borrower families in Region IX were 4 county units in Utah, with a total enrollment of 790 families. By June, 1941, 10 units in 16 counties in Utah and California were in operation, with a 111.6 percent increase in the number of borrower families participating. The 1672 families taking part in these units at the end of the year included 1213 FSA borrowers or 55 percent of the eligible borrower families in the areas involved. Three of the medical care groups in Utah included a total of 453 non-borrower families, a situation discussed later in this report.

The following table shows the expansion of the program in Region IX from the time when the first county unit started in Utah:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
California				7
Utah	1	1	4	9
	1	1	4	16

The usual form of organization in these medical care units in Region IX is the unincorporated health association. A positive effort is being made in the region to shift more responsibility to the borrowers through assigning them definite duties related to the operation of the health association. It is worthy of note that the more recently organized associations in the region, those set up in 1941, are potentially the media for the purchasing or marketing of any services or goods needed by the members. The board of directors of one of these associations is formed by having the borrowers in each neighborhood elect a representative to serve on the board. The various board members are responsible for holding meetings of the members in their particular neighborhoods, usually four such meetings each year, for the purpose of acquainting the members with current developments and getting ideas from the membership which may be passed on to the board. The treasurers of these associations, who are borrowers, may act as trustees of the medical care funds.

Arizona. Since April, 1939, there has been a working agreement with the Arizona State Medical Association. In May, 1941, the Association approved the development of a medical care plan for FSA borrowers in Maricopa County which was also approved by the Maricopa County Medical Society prior to the end of the fiscal year. This plan, which is designed to meet the needs of approximately 400 borrower families in the County, is to be administered by the Agricultural Workers Health and Medical Association, the organization handling the medical care program for migratory agricultural workers in Arizona and California. The plan calls for annual payments of $35 per family for home, office, clinic and hospital care rendered by physicians and for 10 days' hospital care in any one illness. In general, the services are confined to care in acute conditions, although a desirable exception to this is that any chronic conditions among children are to be handled under the plan. It is expected that families living near a clinic operated by the AWH&MA will receive such care as may be appropriate through the clinic and that they will be referred to local physicians of their choice for services not readily available through the clinic. Each of these clinics is staffed by local physicians serving in rotation.

Physicians are to be paid in accordance with the regular fee schedule of the AWH&MA, without proration, and any excess of costs over total family contributions is to be met by AWH&MA funds. This program, which differs rather markedly from the usual pattern, must be considered experimental in character.

California. The California Physicians' Service, an organization set up by the California Medical Association to operate prepayment plans of medical care, was designated by the California Medical Association as the agency to cooperate with the Farm Security Administration in developing a medical care program for FSA borrowers. Consequently, the California Physicians' Service and the FSA initiated an experimental program on June 1, 1941, which is confined to approximately 300 borrower families and is to be considered a one-year experiment. The thought is that this trial program may provide the basis for a revised and mutually satisfactory program for all borrower families in California.

The California Physicians' Service is composed of over 5300 licensed physicians. In its regular program which covers about 27,000 persons, it offers physicians' and surgeons' care and hospitalization to groups of employed individuals at an annual cost of $30 per person. In the experimental program for FSA borrowers, the families pay annual rates which vary with the size of family and which in actual experience average approximately $48.75. Typical rates are $30 for one person, $42.50 for two, $51.50 for five, and $60 for nine or more.

The services provided borrowers through the CPS plan include medical and surgical care in the office, home or hospital. A fee of $1.50 must be paid for the first home call in any illness. Care of chronic or preexisting conditions is excluded except in the case of children under 18 who may receive such care including corrective surgical care. Hospital care is limited to 10 days for any one illness and is provided for obstetrical cases only in special instances. Drugs including biologicals are included but the family must pay the first $1.50 toward the cost of prescribed drugs in each illness. Necessary X-ray and laboratory services are provided.

On June 1, 1941, three medical care units operating under the CPS plan were initiated in 7 counties in California. As of June 30, there was a total of 264 families or 1108 persons enrolled. These families constituted 70.4 percent of those eligible in the 7 counties. The average membership fee in the Monterey Farmers' Health Association was $48.43 as of June 30; that in the North Coast Farmers' Association was $50.27, and that in the Farmers' Health Association (Butte County) was $48.04.

Nevada. There were no particular developments during the fiscal year in Nevada which has a scattered caseload of less than 500 families.

Utah. During the past year there was an increase from 4 county medical care units to 7 units in 9 counties. There was an increase of 78 percent in the number of families enrolled, bringing the total up to 1408 families. The 955 FSA families constituted 52 percent of those eligible in the 9 counties concerned. In the 4 county units which operated throughout the fiscal year there was a 10.8 percent

increase in the number of enrolled families, and the FSA families taking part in the 4 units constituted 72 percent of those eligible as of June, 1941.

Three of the health associations in Utah include a large proportion of non-FSA borrowers, those located in San Juan, Grand and Wayne Counties. The combined membership of these three associations includes 453 non-FSA borrower families as against 158 families on the FSA rolls. These associations operate in isolated areas and serve primarily as mechanisms for assuring a guaranteed minimum income to physicians who settle there. In San Juan and Wayne Counties the existence of the associations is responsible for bringing professional care to areas where either none had been available or where physicians had come and gone because of their inability to attain security. In each instance the physicians concerned are anxious to build up the membership of the associations and they have no desire to restrict membership to particular groups. While FSA personnel were largely responsible for the initiation of these plans, the plans are not, except for Wayne County, looked upon as FSA programs.

The plans in the other four medical care units in Utah are more typical. Annual family membership rates are set at $30 and the services ordinarily include physicians' and surgeons' care, limited hospitalization and prescribed drugs. An interesting innovation, an adaptation of the method of payment used in the Utah dental care program, is an arrangement in connection with the unit recently organized in Uintah and Duchesne Counties whereby 50 percent of funds allocated for physicians' care is set aside until the end of the fiscal year to be available at that time to supplement incomplete payments made to physicians during the year. The thought is that this may provide a more equitable distribution of the funds. A somewhat similar plan is being tried in certain counties in Region III.

Region X

Colorado (49 Counties), Montana, Wyoming

As a direct result of the notable advance made in extending the program in Montana, there was a general expansion of the program in Region X from 8 medical care units in 9 counties in June, 1940, to 22 units in 43 counties in June, 1941. There was an increase of over 300 percent in the number of families enrolled throughout the region, with 3260 families or 16,364 persons participating at the end of the fiscal year. For those units in the three states which were operating both in June, 1940 and in June, 1941, there was an increase of 14.3 percent in the number of enrolled families. As of the end of the year, plans had been approved by county medical societies for extension of the program into 7 additional counties in the three states.

The following table illustrates the growth of the medical care program in Region X since it began approximately three years ago:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1939	June 1940	June 1941
Colorado	2	3	7
Montana	2	2	30
Wyoming		4	6
	4	9	43

As in a number of other regions, considerable difficulty is being encountered in enrolling a sufficiently high proportion of FSA borrowers in the various plans organized. The families enrolled in all of the units as of June, 1941, represented 43.2 percent of the families eligible in the 43 counties concerned. The families in those units operating since previous fiscal years represented 52 percent of the number of families eligible.

The form of organization followed in Region X is that of unincorporated health associations, with boards of directors elected by the borrowers. These boards have proved their worth not only as advisory bodies, but as a medium for informing the member families thoroughly as to their privileges under the plans. In the Wyoming plans, the trustees of the medical care funds are "neutral" persons; in the Montana program they are physicians known as "medical directors"; and in Colorado, certain of the trustees are physicians and others are neither physicians, borrowers nor FSA employees.

Although the scope of services offered in the various medical care units in Colorado and Wyoming varies considerably, there is a common pattern in all but one of the 11 units in Montana. In the Montana program, which has a flat annual rate of $30 per family, all reasonable physicians' and surgeons' services are provided including the services of such specialists as radiologists. Treatment is not limited to acute conditions but on the other hand is available in cases where corrective surgery, for example, is required. It is evident from reports received from Montana that a considerable proportion of the funds expended represent payments to physicians for such preventive services as health examinations, for surgical corrective work including a considerable number of tonsillectomies and hernia repairs, and for X-rays and laboratory work.

Colorado. In the 49 counties in Colorado included in Region X, despite the somewhat unreceptive attitude of many representatives of the medical profession there was an increase from 3 county units to 6 units in 7 counties during the fiscal year. The 606 families enrolled at the end of the year represented 53.8 percent of those eligible in the 7 counties.

In the county units which were operating both in June 1940 and in June 1941, there was an increase of 61 percent in the number of enrolled families, with the membership at the end of the year representing 55 percent of those eligible. It is of interest that non-borrowers are eligible to become members of the health associations in 2 county units in Colorado provided that they are acceptable both to the boards of directors and to the county medical societies.

Montana. The Medical Association of Montana has been unusually co-operative in backing up the efforts of FSA representatives in their approach to local medical societies throughout the State. With this backing, and with the active support of the FSA State Office in Montana, the program organized along the lines previously referred to was extended during the past fiscal year into 28 of the 56 counties in the State. Taking the two-county unit previously in operation into account, there was an increase from 1 unit in 2 counties to 11 units in 30 counties, with an enrollment of 2209 families as of June, 1941. Despite the wide extension of the program from the geographical standpoint, there was still the problem of inadequate enrollment to be faced, for at the end of the year only 39 percent of the families eligible were enrolled.

A number of non-FSA borrower families are members of health associations in Montana, the total number in units of the usual type being 303 families at the end of the year. These families were, of course, enrolled with the approval of the medical societies concerned.

Toward the end of the fiscal year the Medical Association of Montana reviewed the operation of the program to date and recommended very little in the way of change except to declare thatmedical services should in every case include laboratory and X-ray work without extra charge.

Wyoming. In June, 1940 there were 4 county units operating in Wyoming and by June, 1941 this number had increased to 5 units in 6 counties. The 445 families enrolled at the end of the year represented 53.5 percent of those eligible. In the four units which operated throughout the year there was an increase of only 1 percent in the number of enrolled families.

The unit operating in Weston County was to be suspended temporarily at the end of the fiscal year. The physicians in the County were not satisfied with the agreement which they had entered into to provide surgical as well as medical services inasmuch as surgical cases had to be sent outside the County. It is probable that this unit will be reinstituted. More than counterbalancing this loss was the approval by medical societies in three aditional counties of units to be placed in operation early the following year. Moreover, there was a better working relationship with the medical profession throughout the State and it was felt that future expansion of the program could be anticipated.

Region XI

Idaho, Oregon, Washington

The past fiscal year has seen the extension of the medical care program into the State of Washington for the first time. The other outstanding development in the region with respect to the health program for families on the rehabilitation rolls was the action taken by the Idaho State Medical Association in June, 1941, when the Association went on record as permitting the constituent county medical societies to cooperate in developing medical care plans for FSA borrowers if they desired to do so.

There was a general increase in the number of medical care units operating in Region XI from one unit in Idaho, in Bear Lake County, to 8 units in 11 counties in Idaho and Washington. As of June, 1941, 863 families were enrolled in these various units, representing 45.3 percent of the families eligible. The number of counties covered at the end of the fiscal year does not represent fairly all the progress made during the year, for the approval of several additional medical societies had been secured for extension of the program early in the following fiscal year.

The following table shows the extent of the program in Region XI during the past four years:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
Idaho	4	2	1	5
Washington				6
	4	2	1	11

The usual form of organization in Region XI is the unincorporated health association, although it appears that any groups organized in Oregon must be incorporated to avoid coming under the State Hospital Association law which requires the posting of a $10,000 bond.

The plans being developed in the region are broad in the scope of services provided. All of the plans in operation include physicians' services, emergency surgical and hospital care, and ordinary drugs. Some of them include emergency dental extractions as well.

Idaho. Although there has been a general understanding that FSA representatives migh approach county medical societies in Idaho, it was not until June, 1941, that the House of Delegates of the Idaho State Medical Association took favorable action concerning the program. The Association left details of any plan to be decided upon by the local medical societies desiring to cooperate with the Farm Security Administration.

There was an increase in Idaho from one county unit to 4 units in 5 counties. The 537 families enrolled at the end of the fiscal year repsented 51.4 percent of those eligible in the five counties concerned. By the end of the year the approval of county medical societies had been secured for extension of the program into ten additional counties in the State. It is of interest that FSA borrower families in Caribou County, Idaho, are taking part in the medical care unit in Lincoln County, Wyoming, an arrangement which not only crosses state but regional lines.

Oregon. In September, 1939, the Oregon State Medical Society indicated that FSA representatives might negotiate with county medical societies throughout the State with a stipulation that special permission must be secured before approaching any medical society and that any plan agreed upon locally must be submitted to the State Society for approval. The helpful cooperation extended by so many other state medical associations has never been forthcoming in Oregon, and as a consequence there are still no medical care plans in actual operation. Nevertheless, several physicians in Crook and Deschutes Counties in eastern Oregon have expressed their willingness to enter into an agreement with FSA borrowers in the areas and tentative plans have been made for initiating a program at $30 per family which would provide general medical care, emergency surgical care and hospitalization, and ordinary drugs.

Washington. The first medical care plans to go into effect in Washington were placed in operation during the fiscal year, there being 4 medical care units in 6 counties active as of June, 1941. A problem faced in other states was already evident in that the 331 families enrolled at the end of the year represented only 38.3 percent of those eligible in the six counties. The annual rates in the 4 units average approximately $30 for rather broad services confined largely to acute conditions. In one county, emergency dental extractions were included in the plan as well as the services offered in the other units, namely, physicians' and surgeons' care, limited hospitalization and ordinary drugs. At the end of the year the approval of the county medical society had been secured for a unit in one additional county and negotiations were in progress in several other counties.

Region XII

Colorado (14 counties), Kansas (25 counties), New Mexico, Oklahoma (3 counties), Texas (47 counties)

In general there is evidence of a good working relationship with the medical profession in New Mexico and in the portions of the other four states which comprise Region XII. It is of interest that reports from the region indicate that many physicians are insistent that the medical program, broad as it is in the region, be made more inclusive.

During the past fiscal year there was an increase from 31 units in 72 counties to 36 units in 78 counties in all five states in the region, but there was a decrease of 2 percent in the number of families enrolled. The 5395 families participating in the various units as of June, 1941, represented 56.3 percent of those eligible in the 78 counties concerned. In those units which operated throughout the fiscal year, there was an average decrease of 6.1 percent in the number of enrolled families although there were slight increases in the units in Colorado and Texas. During the year three counties were dropped from the program, one of them being a county in Kansas which had been incorporated in the Southwest Kansas district plan and the other two being county units in New Mexico, one of which started on February 1, 1941, and was suspended shortly thereafter.

The following table shows the status of the program in Region XII from the point of view of the number of counties covered from its beginning in June, 1938:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
Colorado			3	6
Kansas		25	25	24
New Mexico		7	22	20
Oklahoma		2	1	3
Texas	1	11	21	25
	1	45	72	78

In general, the services provided in the Region XII plans are quite comprehensive in scope although in most of the units the emphasis is on the care of acute conditions. Annual family rates range in general from about $25 to $35. During the past year three county plans have operated on a capitation basis, but at least one of these plans is going to be reconverted to the fee-for-service basis under which it operated during its first two years.

A few health associations have been organized in Region XII, but in general the form of organization is that of simple trusteeships. The policy in the region is to work toward the organization of more associations, to the end that the borrowers may assume an increasing share of responsibility for dealing with the physicians and for securing an active satisfied membership.

Colorado. There was an increase from 3 county units to 5 units in 6 counties in the 14 county area of Colorado included in Region XII. The 410 families enrolled at the end of the year represented only 35 percent of the families eligible in the 6 counties. For the two units which operated throughout the year for which records are available there was an increase of 5.3 percent in the number of families enrolled.

Kansas. In June, 1940, there were 4 medical care units covering all of the 25 counties in the Region XII part of Kansas. As of June, 1941, there were 6 units in 24 counties and the 16-county district plan in southwest Kansas also included the three counties in the Oklahoma panhandle. There was a rather marked decrease in the number of families enrolled in the Kansas units, there being a decrease of 33.7 percent. The 754 families taking part at the end of the year represented 42 percent of those eligible. In the four units which operated throughout the year, there was a decrease of 35.6 percent in the number of families enrolled.

Several changes have taken place in the Southwest Kansas Mutual Aid Association during the past two years. During the first year of its operation the membership dues were $30 per family and the services provided included general practitioner care, emergency surgical care and hospitalization, prescribed drugs and emergency dental care. In its second year of operation, the provision of drugs was excluded and the physicians received a higher percentage of payment on their bills. For its third fiscal year, that for the year starting May 1, 1941, the annual family rates have been increased to $35 and the treatment of certain chronic conditions interfering with the health or rehabilitation of the individuals enrolled has been included in the plan. Hospital bills still constitute preferred charges which are paid in full before payments are made to physicians and dentists.

New Mexico. Whereas there were 12 medical care units in 22 counties operating in New Mexico in June, 1940, there were 12 units in 20 counties operating in June, 1941. There was a decrease of 13.4 percent in the number of families enrolled. The 2441 families belonging to the 12 groups in June 1941 represented 67.6 percent of those eligible in the 20 counties. In the 11 units which operated throughout the year, there was a decrease of 12 percent in the number of enrolled families.

Oklahoma. Borrower families in one of the three counties in the Oklahoma panhandle for a time maintained a medical care unit of their own. But the more feasible arrangement seems to be for the families living in this part of Oklahoma, which lies within Region XII, to secure their medical care through units in adjacent Kansas and Texas counties. Since many of these families were enrolled in the Southwest Kansas Mutual Aid Association as of June, 1941, the names of these three counties have been listed under that district unit in Table No. 6.

Texas. In the 47 counties in Texas included in Region XII, there was an increase during the fiscal year from 12 medical care groups in 21 counties to 13 groups in 25 counties, with an increase of 37 percent in the number of families enrolled. The 1790 families who were members of the groups in June, 1941, represented 56 percent of those

eligible in the 25 counties concerned. In the 12 units which operated thoughout the fiscal year, there was an increase of 30 percent in the number of enrolled families, with the total number of families at the end of the year representing 70 percent of those eligible.

An experimental hospitalization plan was put into effect on September 1, 1940, in connection with medical care units in five Texas counties. This plan, administered by Group Hospital Service, Inc., of Texas, cost the families $7 per year for certain emergency hospitalization benefits. In general, the benefits were originally confined to accidents and other emergency surgical cases, covering a maximum of 14 days' ward care per case, but after the plan had operated six months, a flat $25 benefit to cover 4 days' care was added to cover all obstetrical cases. As of the end of the fiscal year, it was evident that Group Hospital Service was able to pay the hospital bills in the five counties at the minimum rates negotiated and to accumulate a moderate surplus.

Table No. 2

Status of group medical care program (except units restricting membership to occupants of resettlement projects) on June 30,1940 and June 30,1941, showing, for each region and state, the number of units, the number of counties involved, the number of families and persons holding membership and the number and percentage increase or decrease in families during the year.

Region and State	June 30, 1941				June 30, 1940				Increase or Decrease(a) in Families	
	No. of Units	No. of Counties	No. of Families	No. of Persons	No. of Units	No. of Counties	No. of Families	No. of Persons	Total	Percent
U. S. Total	703	881	104,224	545,673	546	639	78,053	413,382	26,171	33.5
Region I	11	46	1,597	7,841	4	19	540	2,746	1,057	195.7
New Hampshire	1	2	41	189	1	2	46	220	- 5	- 10.8
New Jersey	1	19	397	1,839	1	1	66	242	331	501.5
New York	3	4	328	1,550						
Pennsylvania	5	7	390	1,932	1	2	69	371	321	465.2
Vermont	1	14	441	2,331	1	14	359	1,913	82	22.8
Region III	111	116	7,519	36,499	53	55	2,766	13,064	4,753	171.8
Illinois	9	10	643	3,111	5	5	366	1,653	277	75.7
Indiana	5	6	207	1,114	3	4	79	447	128	162.0
Iowa	3	3	335	1,483	1	1	103	448	232	225.2
Missouri	54	56	3,492	16,943	27	28	1,286	6,097	2,206	171.5
Ohio	40	41	2,842	13,848	17	17	932	4,419	1,910	204.9
Region IV	77	102	7,912	45,609	61	84	5,109	29,000	2,803	54.9
Kentucky	3	3	277	1,582	4	4	250	1,366	27	10.8
North Carolina	33	38	4,362	26,144	29	35	2,788	15,811	1,574	56.5
Tennessee	17	20	1,508	7,721	8	10	567	2,996	941	166.0
Virginia	17	34	1,359	8,073	13	28	1,276	7,733	83	6.5
West Virginia	7	7	406	2,089	7	7	228	1,094	178	78.1

(a) - indicates decrease

Region and State	June 30, 1941 No. of Units	No. of Counties	No. of Families	No. of Persons	June 30, 1940 No. of Units	No. of Counties	No. of Families	No. of Persons	Increase or Decrease (a) in Families Total	Percent
Region V	181	187	33,285	182,419	162	164	29,492	164,719	3,793	12.9
Alabama	40	40	14,675	81,473	33	33	11,677	65,233	2,998	25.7
Florida	4	6	320	1,894	5	5	572	2,952	- 252	- 44.1
Georgia	117	121	15,055	83,076	106	108	13,995	77,267	1,060	7.6
South Carolina	20	20	3,235	19,121	18	18	3,248	19,267	- 13	- .4
Region VI	146	148	29,372	149,434	130	131	19,858	102,616	9,514	47.9
Arkansas	60	59	11,624	57,214	68	68	10,914	56,586	710	6.5
Louisiana	30	30	6,046	30,569	21	21	2,859	14,753	3,187	111.5
Mississippi	56	59	11,702	61,651	41	42	6,085	31,277	5,617	92.3
Region VII	53	85	7,479	37,696	42	48	7,412	38,015	67	.9
Kansas	24	28	2,970	14,919	20	20	3,344	16,922	- 374	- 11.2
Nebraska	28	43	4,008	20,473	22	28	4,068	21,093	- 60	- 1.4
South Dakota	1	14	501	2,304						
Region VIII	48	49	5,365	29,699	50	52	5,667	29,905	198	3.5
Oklahoma	22	22	3,283	16,559	23	23	2,761	14,803	522	18.9
Texas	26	27	2,532	13,140	27	29	2,906	15,102	- 324	- 11.1
Region IX	10	16	1,572	8,795	4	4	790	4,417	882	111.6
California	3	7	264	1,108						
Utah	7	9	1,408	7,687	4	4	790	4,417	618	78.2
Region X	22	43	3,260	16,364	8	9	813	4,114	2,447	301.0
Colorado	6	7	606	3,067	3	3	306	1,526	300	98.0
Montana	11	30	2,209	11,034	1	2	124	625	2,085	1681.5
Wyoming	5	6	445	2,263	4	4	383	1,963	62	16.2

(a) - indicates decrease

Region and State	June 30, 1941 No. of Units	No. of Counties	No. of Families	No. of Persons	June 30, 1940 No. of Units	No. of Counties	No. of Families	No. of Persons	Increase or Decrease (a) in Families Total	Percent
Region XI	8	11	868	4,205	1	1	103	576	765	742.7
Idaho	4	5	537	2,736	1	1	103	576	434	421.4
Washington	4	6	331	1,469						
Region XII	36	78	5,395	27,112	31	72	5,503	29,210	- 108	- 2.0
Colorado	5	6	410	1,952	3	3	236	1,179	174	73.7
Kansas	6	(b)27	754	3,397	4	25	1,138	6,368	- 384	- 33.7
New Mexico	12	20	2,441	13,340	12	22	2,820	15,124	- 379	- 13.4
Texas	13	25	1,790	8,423	12	(c)22	1,309	6,539	481	36.7

(a) - indicates decrease
(b) Includes 3 Oklahoma counties.
(c) Includes 1 Oklahoma county.

Table No. 3

Increase or decrease in number of member families during the fiscal year 1940-41 for group medical care units which had begun operation prior to this fiscal year, and percentage of eligible FSA borrowers who held membership in these units on June 30, 1941.

Region	State	No. of Units	No. of Counties	No. of Families June 30, 1941	No. of Families June 30, 1940	Increase or Decrease* Families	Increase or Decrease* Per Cent	Percent of Families Eligible Holding Membership June 30, 1941
	U. S. Total	487	566	77,714	70,276	7,438	10.6	63.5
I		4	19	598	540	58	10.7	49.6
	New Hampshire	1	2	41	46	- 5	- 11.9	41.4
	New Jersey	1	1	54	66	- 12	- 18.2	45.4
	Pennsylvania	1	2	62	69	- 7	- 10.1	50.8
	Vermont	1	14	441	359	82	22.8	50.9
III		46	47	2,900	2,351	549	33.4	35.9
	Illinois	4	4	320	299	21	9.2	51.3
	Indiana	3	4	106	79	27	34.2	36.0
	Iowa	1	1	106	103	3	2.9	70.7
	Missouri	22	22	1,250	1,031	219	21.2	28.8
	Ohio	16	16	1,113	839	279	33.3	41.7
IV		54	66	5,628	4,441	1,187	26.7	44.2
	Kentucky	3	3	277	178	99	55.6	19.6
	North Carolina	25	30	3,341	2,459	882	35.9	53.4
	Tennessee	8	9	685	526	159	30.2	52.2
	Virginia	11	17	919	1,050	- 131	- 12.5	36.9
	West Virginia	7	7	406	228	178	78.1	32.4
V		144	146	27,519	26,272	1,247	4.7	81.2
	Alabama	30	30	12,027	10,374	1,653	15.9	93.7
	Florida	3	3	266	306	- 40	- 13.1	48.9
	Georgia	98	100	13,223	13,365	- 142	- 1.1	76.0
	South Carolina	13	13	2,003	2,227	- 224	- 10.1	64.7

* - indicates decrease

Region	State	No. of Units	No. of Counties	No. of Families June 30,1941	No. of Families June 30,1940	Increase or Decrease* Families	Increase or Decrease* Per Cent	Percent of Families Eligible Holding Membership June 30, 1941
VI		115	116	23,046	17,644	5,402	30.3	66.7
	Arkansas	59	59	10,937	9,566	1,371	14.3	65.6
	Louisiana	21	21	4,599	2,859	1,740	60.9	57.7
	Mississippi	35	36	7,510	5,219	2,291	42.5	75.8
VII		41	48	6,167	7,318	-1,151	- 15.7	58.8
	Kansas	20	20	2,772	3,344	- 572	- 17.1	59.2
	Nebraska	21	28	3,395	3,974	- 579	- 14.6	58.5
VIII		42	43	5,078	4,804	274	5.7	49.9
	Oklahoma	21	21	3,123	2,572	551	21.4	48.0
	Texas	21	22	1,955	2,232	- 277	- 12.4	53.5
IX	Utah	4	4	875	790	85	10.8	72.4
X		7	8	782	684	98	14.3	52.1
	Colorado	2	2	285	177	108	61.0	55.0
	Montana	1	2	110	124	- 14	- 11.3	36.8
	Wyoming	4	4	387	383	4	1.0	56.5
XI	Idaho	1	1	117	103	14	14.0	51.5
XII		29	68	5,004	5,329	- 325	- 6.1	60.4
	Colorado	2	2	177	168	9	5.3	41.5
	Kansas	4	25	733	1,138	- 405	- 35.6	37.2
	New Mexico	11	19	2,394	2,714	- 320	- 12.0	69.2
	Texas	12	22	1,700	1,309	391	29.9	69.9

* - indicates decrease

Table No. 4

Number of rural rehabilitation, resettlement project, and other (mostly tenant purchase) FSA families for whom membership is available in medical care groups (except groups restricting membership to occupants of resettlement projects) and number and percentage of such families, and number of non-FSA families, holding membership in these groups in each region.

Region	Eligible Families				Member Families					Percent of eligible families holding membership			
	Total	RR	RP	Other FSA	Total	RR	RP	Other FSA	Non-FSA	*Total	RR	RP	Other FSA
U. S.	170,317	157,071	1,663	11,583	104,224	98,263	1,037	3,813	1,111	60.5	62.6	62.4	32.9
I	3,146	3,062	27	57	1,597	1,544	17	36		50.8	50.4	63.0	63.2
III	19,437	18,724	295	418	7,519	7,150	161	198	10	38.6	38.2	54.6	47.4
IV	16,874	16,104	312	458	7,912	7,436	230	246		46.9	46.2	73.7	53.7
V	39,474	38,865	217	392	33,285	32,951	176	158		84.3	84.8	81.1	40.3
VI	43,888	42,249	380	1,259	29,372	28,699	220	435	18	66.9	67.9	57.9	34.5
VII	12,916	11,178	16	1,722	7,479	6,507	2	670	300	55.6	58.2	12.5	38.9
VIII	11,836	11,249	49	538	5,865	5,751	18	96		49.6	49.6	36.7	17.8
IX	2,186	2,139	12	35	1,672	1,197	7	9	459	55.5	56.0	58.3	25.7
X	6,815	4,026	298	2,491	3,260	2,176	151	618	315	43.2	54.0	50.7	40.3
XI	1,910	1,895		15	868	862		6		45.3	45.5		40.0
XII	11,835	7,580	57	4,198	5,395	3,990	55	1,341	9	56.3	52.6	96.5	31.9

* Non-FSA membership was left out of account in computing this percentage.

Extent to which medical care groups in each region offer the service of physicians, surgeons, hospitals, druggists and dentists; measured by the percentage of the total family membership to whom each service is offered. (Units offering dental service only are excluded.)

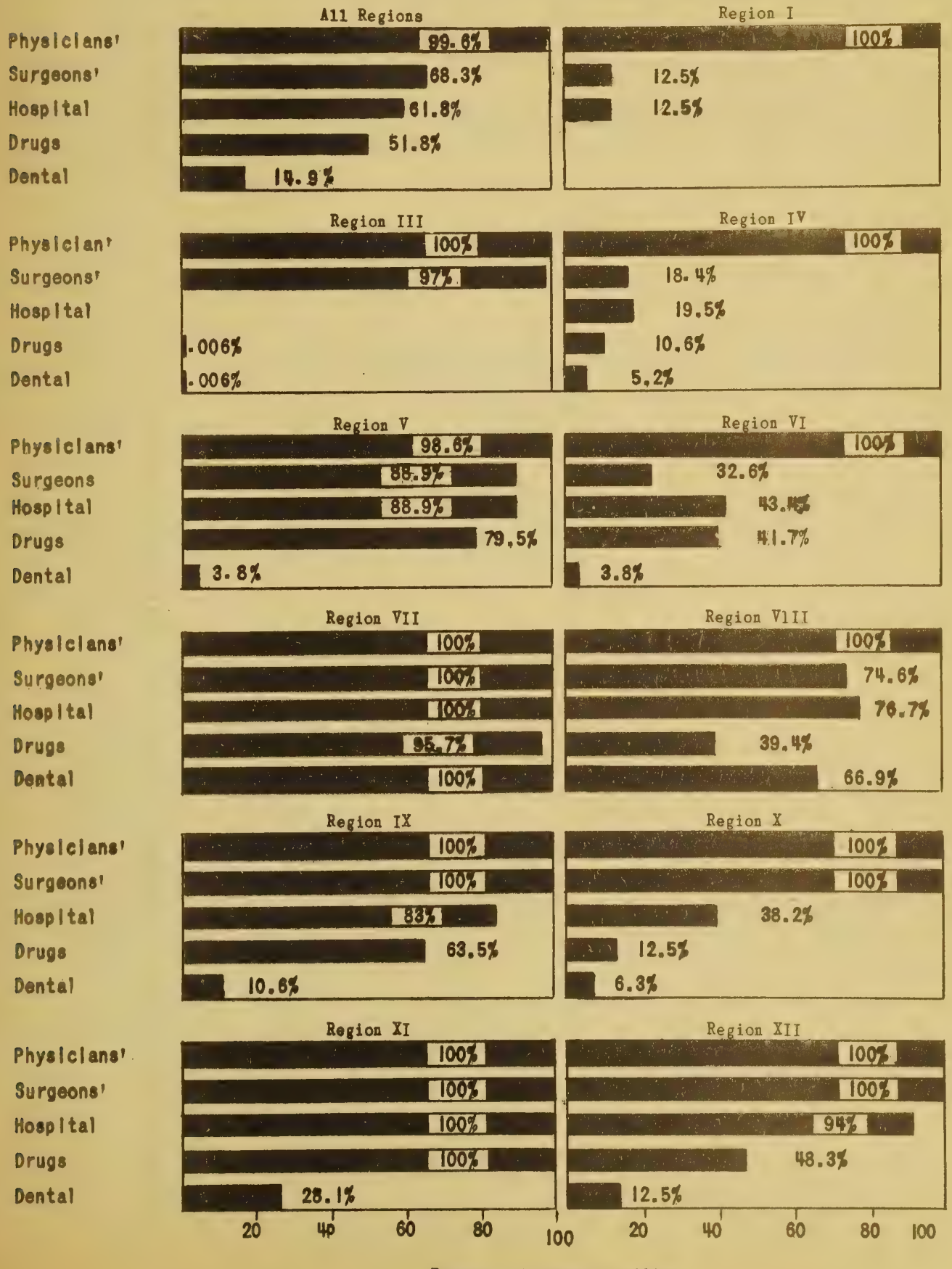

Table No. 5

Number of group medical care units (except units restricting membership to occupants of resettlement projects) in each state by type of service offered and plan of operation, showing number of counties represented, the membership and its distribution by type of service, the average annual membership fee paid for the different combinations of service and the percentage relationship of this fee to the average annual net income of FSA borrowers.

	Type of Service	Plan of Operation	No. of Units	No. of Counties	No. of Families	No. of Persons	Percent of families by type of Service	*Average Annual Income	Average Annual Membership Fee Amount	Average Annual Membership Fee % of Income
U.S. Total			703	881	104,224	545,673	100.			
	1	Fee	98	147	13,483	72,961	13.9	660	15.16	2.29
		Cap.	3	3	784	4,465		456	16.70	3.66
		Ind.	5	5	178	705		721	16.92	2.35
	1,2	Fee	123	146	10,143	49,502	10.0	805	24.01	2.98
		Cap.	1	1	284	1,540		1084	25.00	2.31
	1,2,3	Fee	105	130	14,932	76,277	15.7	587	28.32	4.82
		Cap.	8	8	1,412	7,475		671	21.15	3.15
	1,2,3,4	Fee	119	138	26,063	142,507	28.6	428	18.59	4.34
		Cap.	18	19	3,692	18,440		376	17.45	4.64
	1,2,3,4,5	Fee	74	108	9,846	50,515	9.4	636	29.37	4.62
	1,2,3,5	Fee	21	39	3,467	17,216	3.4	591	23.14	3.92
		Cap.	2	2	141	821		1075	45.16	4.20
	1,2,4	Fee	3	4	285	1,570	.3	562	20.63	3.67
	1,2,5	Fee	3	3	224	1,103	.2	669	20.56	3.07
	1,3	Fee	25	30	3,677	17,808	3.5	602	15.33	2.55
	1,3,4	Fee	1	1	229	1,129	.2	596	16.00	2.68
	1,3,5	Fee	3	3	578	3,005	.6	692	17.73	2.56
	1,4	Fee	56	58	10,031	52,446	12.4	446	16.92	3.79
		Cap.	21	21	2,943	16,007		437	16.42	3.76
	1,4,5	Fee	9	10	980	5,133	1.0	602	19.22	3.19
		Cap.	1	1	76	395		443	14.04	3.17
	1,5	Fee	2	2	322	1,648	.3	682	14.92	2.19
	2,3	Fee	2	2	454	3,005	.4	537	3.88	.72

* Average annual income for U.S. total of families receiving different types of service has been estimated from the state average annual income of these families. Average annual income for each region is also estimated from the state average annual incomes of the families making up the regional total of families.

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership		Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee	
					Families	Persons			Amount	% of Income
Region I Total			11	46	1597	7841	100.0	1046.		
	1	Fee	9	44	1398	6905	87.5		16.65	1.58
	123	Fee	2	2	199	936	12.5		29.65	2.83
New Hampshire Total	1	Fee	1	2	41	189	100.0	1154.	17.76	1.54
New Jersey Total	1	Fee	1	19	397	1839	100.0	974.	17.04	1.75
New York Total			3	4	328	1550	100.0	920.		
	123	Fee	2	2	199	936	60.6		29.65	3.22
	1	Fee	1	2	129	614	39.4		18.60	2.02
Pennsylvania Total	1	Fee	5	7	390	1932	100.0	960.	17.98	1.87
Vermont Total	1	Fee	1	14	441	2331	100.0	1271.	19.44	1.53
Region III Total			111	116	7519	36499	100.0	712.		
	1	Fee	1	1	49	261	3.0		22.68	3.19
		Indiv.	5	5	178	705			16.92	2.38
	12	Fee	104	109	7250	35229	96.4		22.69	3.19
	124	Fee	1	1	42	304	.6		26.00	3.65
Illinois Total	12	Fee	9	10	643	3111	100.0	797.	23.00	2.89
Indiana Total			5	6	207	1114	100.0	743.		
	1	Fee	1	1	49	261	23.7		22.68	3.05
	12	Fee	4	5	158	853	76.3		23.09	3.11
Iowa Total	12	Fee	3	3	335	1483	100.0	826.	23.44	2.84
Missouri Total			54	56	3492	16943	100.0	625.		
	1	Indiv.	3	3	70	303	2.0		27.75	4.44
	12	Fee	50	52	3380	16336	96.8		23.00	3.68
	124	Fee	1	1	42	304	1.2		26.00	4.16
Ohio Total			40	41	2842	13848	100.0	784.		
	1	Indiv.	2	2	108	402	3.8		26.09	3.33
	12	Fee	38	39	2734	13446	96.2		22.12	2.82
Region IV Total			77	102	7912	45609	100.0	756.		
	1	Fee	48	58	5757	33627	72.8		15.01	1.98
	123	Fee	13	20	899	5026	11.4		19.50	2.58
	1234	Fee	4	5	442	2477	5.6		24.43	3.23
	13	Fee	4	9	201	1197	2.5		20.58	2.72

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership		Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee	
					Families	Persons			Amount	% of Income
Region IV cont'd.	14	Fee	3	4	200	1114	2.5		13.59	2.46
	15	Fee	1	1	101	549	1.3		15.00	1.98
	145	Fee	4	5	312	1619	3.9		16.18	2.14
Kentucky Total			3	3	277	1502	100.0	787.		
	1	Fee	2	2	147	833	53.1		14.41	1.83
	123	Fee	1	1	130	749	46.9		15.70	1.99
North Carolina Total			33	38	4362	26144	100.0	778.		
	1	Fee	32	36	4260	25634	97.7		14.77	1.90
	1234	Fee	1	2	102	510	2.3		21.96	2.82
Tennessee Total			17	20	1508	7721	100.0	710.		
	1	Fee	11	13	1031	5250	68.4		14.98	2.11
	14	Fee	2	2	115	621	7.6		17.85	2.51
	145	Fee	3	4	261	1301	17.3		14.20	2.00
	15	Fee	1	1	101	549	6.7		15.00	2.11
Virginia Total			17	34	1359	8073	100.0	705.		
	1	Fee	3	7	319	1910	23.5		18.66	2.65
	123	Fee	6	13	422	2478	31.1		16.27	2.31
	1234	Fee	2	2	281	1677	20.7		25.17	3.57
	13	Fee	4	9	201	1197	14.8		20.58	2.92
	14	Fee	1	2	85	493	6.3		19.60	2.78
	145	Fee	1	1	51	318	3.8		26.32	3.73
West Virginia Total			7	7	406	2089	100.0	845.		
	123	Fee	6	6	347	1799	35.5		24.86	2.94
	1234	Fee	1	1	59	290	14.5		25.20	2.98
Region V Total			181	187	33285	182419	100.0	363.		
	1	Fee	13	15	1109	6185	3.9		13.88	3.83
		Cap.	1	1	202	1321			16.54	4.56
	123	Fee	26	29	3975	21437	13.3		14.15	3.90
		Cap.	3	3	422	2429			15.38	4.24
	1234	Fee	86	86	20302	112046	71.0		15.91	4.39
		Cap.	15	15	3340	16575			16.22	4.47
	1235	Fee	4	4	618	3520	1.9		15.35	4.23
	12345	Fee	5	5	498	2866	1.5		17.76	4.90

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership		Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee	
					Families	Persons			Amount	% of Income
Region V cont'd.	14	Fee	18	18	1775	19714	6.6		14.67	4.04
		Cap.	6	7	438	2508			15.50	4.27
	145	Fee	1	1	76	418	.4		15.84	4.37
		Cap.	1	1	76	395			14.04	3.87
	23	Fee	2	2	454	3005	1.4		3.88	1.07
Alabama Total			40	40	14675	79020	100.0	249.		
	1234	Fee	32	32	12397	67208	100.0		16.35	6.57
		Cap.	8	8	2278	11812			16.76	6.73
Georgia Total			117	121	15055	82384	100.0	443.		
	1	Fee	10	10	795	4384	5.3		13.21	2.98
	123	Fee	23	26	3557	18971	25.7		13.95	3.15
		Cap.	2	2	315	1823			15.34	3.46
	1234	Fee	48	48	6901	38959	52.0		15.08	3.40
		Cap.	6	6	925	4033			15.05	3.40
	12345	Fee	4	4	333	2255	2.6		18.52	4.18
	1235	Fee	4	4	618	3520	4.1		15.35	3.47
	145	Fee	1	1	76	418	1.0		15.84	3.58
		Cap.	1	1	76	395			14.04	3.17
	14	Fee	14	14	1144	6120	9.3		14.16	3.20
		Cap.	4	5	265	1506			15.40	3.48
South Carolina Total			20	20	3235	19121	100.0	537.		
	1	Fee	1	1	222	1332	13.1		15.99	2.98
		Cap.	1	1	202	1321			16.54	3.08
	123	Fee	3	3	418	2466	16.2		15.89	2.96
		Cap.	1	1	107	606			15.50	2.89
	1234	Fee	5	5	882	5046	31.5		16.16	3.01
		Cap.	1	1	137	730			15.17	2.82
	12345	Fee	1	1	115	611	3.6		15.24	2.84
	14	Fee	3	3	525	3002	21.6		15.60	2.91
		Cap.	2	2	173	1002			15.67	2.92
	23	Fee	2	2	454	3005	14.0		3.88	.72
Florida Total			4	6	320	1894	100.0	476.		
	1	Fee	2	4	92	469	28.8		14.71	3.09

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership Families	Membership Persons	Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee Amount	Average Annual Membership Fee % of Income
Region V cont.										
	14	Fee	1	1	106	592	33.1		15.58	3.27
	1234	Fee	1	1	122	833	38.1		16.82	3.53
Region VI Total			146	148	29372	149434	100.0	502.		
	1	Fee	23	24	4789	24064	18.3		14.93	2.97
		Cap.	2	2	582	3144			16.76	3.33
	12	Fee	3	3	278	1413	.9		17.01	3.39
	13	Fee	21	20	3476	16611	11.8		15.03	2.99
	14	Fee	36	37	8056	41618	36.0		17.83	3.55
		Cap.	15	15	2505	13499			16.58	3.30
	123	Fee	35	35	6795	33993	25.1		16.48	3.28
		Cap.	2	2	572	2860			15.07	3.00
	124	Fee	1	2	130	662	.4		24.00	4.78
	134	Fee	1	1	229	1129	.8		16.00	3.19
	1234	Fee	3	3	754	4127	2.6		21.03	4.19
	12345	Fee	1	1	206	1099	.7		14.88	2.96
	145	Fee	1	1	284	1478	1.0		22.56	4.49
	1235	Fee	2	2	716	3737	2.4		15.98	3.18
Arkansas Total			60	59	11624	57214	100.0	596.		
	1	Fee	1	1	234	941	2.0		19.20	3.22
	123	Fee	32	32	6295	31473	59.0		16.51	2.77
		Cap.	2	2	572	2860			15.07	2.53
	13	Fee	21	20	3476	16611	29.9		15.03	2.52
	12345	Fee	1	1	206	1099	1.8		14.88	2.50
	1234	Fee	1	1	256	1164	2.2		15.84	2.66
	1235	Fee	1	1	356	1837	3.1		15.40	2.58
	134	Fee	1	1	229	1129	2.0		16.00	2.68
Louisiana Total			30	30	6046	30569		465.		
	1	Fee	20	20	4235	21534	70.0		15.37	3.31
	123	Fee	3	3	500	2520	8.3		16.06	3.45
	14	Fee	6	6	1241	6107	21.7		17.60	3.78
		Cap.	1	1	70	408			16.92	3.64
Mississippi Total			56	59	11702	61651	100.0	428		
	1	Fee	2	3	320	1589	7.7		19.17	4.48
		Cap.	2	2	582	3144			16.76	3.92

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership Families	Membership Persons	Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee Amount	Average Annual Membership Fee % of Income
Region VI cont'd.										
	1234	Fee	2	2	498	2963	4.3		23.70	5.54
	1235	Fee	1	1	360	1800	3.1		16.56	3.87
	124	Fee	1	2	130	662	1.1		24.00	5.61
	14	Fee	30	31	6815	35511	79.0		17.87	4.18
		Cap.	14	14	2435	13091			16.57	3.87
	145	Fee	1	1	284	1478	2.4		22.56	5.27
	12	Fee	3	3	278	1413	2.4		17.01	3.97
Region VII Total			53	85	7479	37696	100.0	611.		
	1235	Fee	3	3	319	1523	4.3		30.00	4.91
	12345	Fee	50	82	7160	36173	95.7		30.88	5.05
Kansas Total			24	28	2970	14919	100.0	619.	28.09	4.54
	1235	Fee	3	3	319	1523	10.7		30.00	4.91
	12345	Fee	21	25	2651	13396	89.3		31.48	5.15
Nebraska Total	12345	Fee	28	43	4008	20473	100.0	593.	30.72	5.03
South Dakota Total	12345	Fee	1	14	501	2304	100.0	707.	33.00	5.40
Region VIII Total			48	49	5865	29699	100.0	682.		
	1	Fee	4	4	381	1919	6.5		18.72	2.74
	12	Fee	2	2	114	515	1.9		20.47	3.00
	123	Fee	6	7	584	2996	10.0		22.06	3.23
	1234	Fee	6	6	747	3907	12.7		23.02	3.37
	12345	Fee	9	9	1172	6165	20.0		23.90	3.50
	1235	Fee	10	10	1423	6768	24.3		25.33	3.71
	124	Fee	1	1	113	604	1.9		14.76	2.16
	135	Fee	3	3	578	3005	9.9		17.73	2.60
	145	Fee	3	3	308	1638	5.2		20.06	2.94
	125	Fee	3	3	224	1103	3.8		20.56	3.01
	15	Fee	1	1	221	1099	3.8		14.88	2.18
Oklahoma Total			22	22	3283	16559	100.0	692.		
	1	Fee	1	1	76	395	2.3		16.80	2.43
	123	Fee	2	2	295	1482	9.0		23.97	3.46
	1234	Fee	3	3	496	2547	15.1		24.09	3.48
	12345	Fee	4	4	598	2965	18.2		24.92	3.60
	1235	Fee	5	5	819	3943	25.0		25.30	3.66
	124	Fee	1	1	113	604	3.4		14.76	2.13

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership		Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee	
					Families	Persons			Amount	% of Income
Region VIII cont'd.										
	135	Fee	3	3	578	3005	17.6		17.73	2.56
	145	Fee	3	3	308	1618	9.4		20.06	2.90
Texas Total			26	27	2582	13140	100.0	669.		
	1	Fee	3	3	305	1524	11.8		19.20	2.87
	12	Fee	2	2	114	515	4.4		20.47	3.06
	123	Fee	4	5	289	1514	11.2		20.11	3.01
	1234	Fee	3	3	251	1360	9.7		20.92	3.13
	12345	Fee	5	5	574	3200	22.2		22.83	3.41
	125	Fee	3	3	224	1103	8.7		20.56	3.07
	1235	Fee	5	5	604	2825	23.4		25.37	3.79
	15	Fee	1	1	221	1099	8.6		14.88	2.22
Region IX Total			10	16	1672	8795	100.0	1086.		
	12	Cap.	1	1	284	1540	16.9		25.00	2.30
	123	Fee	1	1	86	409	19.6		35.00	3.22
		Cap.	1	1	241	1245			40.00	3.68
	1234	Fee	6	11	883	11522	52.9		35.60	3.28
	12345	Fee	1	2	178	1079	10.6		30.00	2.76
California Total	1234	Fee	3	7	264	1108	100.0	1100.	48.74	4.43
Utah Total			7	9	1408	7687	100.0	1084.		
	12	Cap.	1	1	284	1540	20.2		25.00	2.31
	123	Fee	1	1	86	409	23.2		35.00	3.22
		Cap.	1	1	241	1245			40.00	3.69
	1234	Fee	3	4	619	3414	44.0		30.00	2.77
	12345	Fee	1	2	178	1079	12.6		30.00	2.77
Region X Total			22	43	3260	16364	100.0	1092.		
	12	Fee	11	28	2177	10769	66.8		30.16	2.76
	123	Fee	5	6	509	2647	17.4		33.60	3.07
		Cap.	1	2	58	331			35.00	3.20
	1234	Fee	1	1	108	347	9.5		30.00	2.74
		Cap.	2	2	203	1179			30.00	2.74
	12345	Fee	1	1	95	475	2.9		35.64	3.26
	1235	Cap.	1	3	110	616	3.4		50.00	4.58

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership		Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee	
					Families	Persons			Amount	% of Income
Region X cont'd.										
Colorado Total			6	7	606	3067	100.0	626.		
	12345	Fee	1	1	95	475	15.7		35.64	5.69
	123	Fee	4	5	433	2241	71.5		34.24	5.47
	12	Fee	1	1	78	351	12.8		34.44	5.50
Montana Total			11	30	2209	11034	100.0	1204.		
	1235	Cap.	1	3	110	616	5.0		50.00	4.15
	12	Fee	10	27	2099	10418	95.0		30.00	2.49
Wyoming Total			5	6	445	2263	100.0	1175.		
	123	Fee	1	1	76	406	30.1		30.00	2.55
		Cap.	1	2	58	331			35.00	2.98
	1234	Fee	1	1	103	347	69.9		30.00	2.55
		Cap.	2	2	203	1179			30.00	2.55
Region XI Total			8	11	868	4205	100.0	1010.		
	1234	Fee	5	8	624	2921	71.9		34.55	3.42
	12345	Fee	3	3	244	1284	28.1		35.57	3.52
Idaho Total			4	5	537	2736	100.0	1054.		
	1234	Fee	2	3	338	1643	62.9		37.94	3.60
	12345	Fee	2	2	199	1093	37.1		36.84	3.49
Washington Total			4	6	331	1469	100.0	940.		
	1234	Fee	3	5	286	1278	86.4		30.56	3.25
	12345	Fee	1	1	45	191	13.6		30.00	3.19
Region XII Total			36	78	5395	27112	100.0	675.		
	12	Fee	3	3	324	1576	6.0		21.73	3.21
	123	Fee	17	29	1885	8833	37.2		25.82	3.82
		Cap.	1	1	119	610			25.92	3.83
	1234	Fee	8	18	2203	12160	43.6		27.92	4.13
		Cap.	1	2	149	686			28.00	4.14
	12345	Fee	4	5	293	1374	5.4		30.00	4.44
	1235	Fee	1	19	391	1668	7.8		35.00	5.18
		Cap.	1	1	31	205			28.00	4.14
Colorado Total			5	6	410	1952	100.0	626.		
	12	Fee	1	1	117	578	28.5		20.00	3.19
	12345	Fee	4	5	293	1374	71.5		30.00	4.79

	Type of Service	Plan of Operation	No. of Units	No. of Counties	Membership		Per Cent of Families by Type of Service	Average Annual Income	Average Annual Membership Fee	
					Families	Persons			Amount	% of Income
Region XII cont'd.										
Kansas Total			6	27	754	3397	100.0	619.		
	123	Fee	4	7	332	1524	44.0		25.94	4.19
	1235	Fee	1	19	391	1668	51.8		35.00	5.65
		Cap.	1	1	31	205	4.2		28.00	4.52
New Mexico Total			12	20	2441	13340	100.0	706.		
	12	Fee	2	2	207	998	8.5		21.74	3.08
	123	Fee	3	3	76	383	3.1		22.26	3.15
	1234	Fee	7	15	2158	11959	88.4		27.96	3.96
Texas Total			13	25	1790	8423	100.0	669.		
	123	Fee	10	19	1477	6926	82.5		25.98	3.88
		Cap.	1	1	119	610			25.92	3.87
	1234	Fee	1	3	45	201	17.5		26.00	3.89
		Cap.	1	2	149	686			28.00	4.18

Table No. 6

Counties having group medical care units
for Farm Security Administration clients, June 30, 1941,
(except units restricting membership to resettlement projects)
by state and types of service offered, showing average membership fee,
number of members and percentage of eligible families holding membership.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6/30/41 Families	 Persons	Percent of eligible families
ALL REGIONS - 703 units in 831 counties				104,224	545,673	60.5
Region I - 11 units in 46 counties				1,597	7,841	50.8
New Hampshire - 1 unit in 2 counties						
Physicians' only	Cheshire, Grafton	Jan. '40	$17.76	41	189	41.4
New Jersey - 1 unit in 19 counties						
Physicians' only	All counties except Hudson & Passaic	May '41	17.93	397	1,839	43.4
New York - 3 units in 4 counties				328	1,550	58.4
Physicians', only	Jefferson, Lewis	July '40	18.60	129	614	64.8
Physicians',	Chenango	Apr. '41	31.68	106	488	47.3
Surgeons',	Washington	July '40	28.30	93	448	66.9
Hospital						
Pennsylvania - 5 units in 7 counties				390	1,932	55.4
Physicians' only	Bradford, Sullivan	Feb. '41	18.36	53	288	53.0
	Crawford	July '40	17.88	170	760	63.9
	Mercer	Jan. '41	18.12	83	437	56.1
	Potter, Tioga	Mar. '40	17.76	62	326	50.8
	Wyoming	Mar. '41	18.00	22	121	32.4
Vermont - 1 unit in 14 counties						
Physicians' only	Statewide 14 counties	July '39	19.44	441	2,331	50.9
Region III - 111 units in 116 counties				7,519	36,499	38.6
Illinois - 9 units in 10 counties				643	3,111	48.0
Physicians',	Adams	Apr. '41	23.00	98	459	49.0
Surgeons'	Bond	July '40	23.00	31	152	77.5
	Brown	Apr. '40	23.00	89	378	56.0
	Fayette	Oct. '40	23.00	52	271	34.7
	Hancock	May '40	23.00	94	454	38.7
	McDonough	June '40	23.00	53	244	58.9
	Monroe, Randolph	Aug. '40	23.00	48	273	58.5
	Schuyler	Mar. '40	23.00	122	564	51.3
	Wayne	May '40	23.00	56	316	40.9

MEMBERSHIP
6-30-41

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Indiana - 5 units in 6 counties				207	1,114	28.8
Physicians' only	Starke	Feb. '39	$22.68	49	261	32.2
Physicians', Surgeons'	Daviess, Martin	Mar. '39	23.52	28	206	15.1
	Franklin	Aug. '40	23.00	63	319	48.5
	Harrison	July '40	23.00	38	206	29.0
	Scott	May '40	23.00	29	122	24.4
Iowa - 3 units in 3 counties				335	1483	59.4
Physicians', Surgeons'	Madison	May '41	23.00	108	493	59.7
	Marion	June '39	23.53	121	545	51.9
	Union	Apr. '39	23.76	106	445	70.7
Missouri - 54 units in 56 counties				3492	16,943	32.2
Physicians', Surgeons'	Andrew	Apr. '41	23.00	51	211	27.7
	Barry	May '40	23.00	32	152	17.3
	Barton	Oct. '40	23.00	37	187	24.0
	Benton	July '40	23.00	41	184	40.6
	Callaway	Apr. '41	23.00	35	155	15.7
	Cape Girardeau	Oct. '40	23.00	59	265	30.7
	Carter, Reynolds	Mar. '41	23.00	90	521	32.7
	Cass	June '40	23.00	86	347	45.7
	Clinton	Apr. '40	23.00	46	193	20.4
	Cole	Nov. '38	23.00	97	486	63.0
	Daviess	June '40	23.00	66	302	24.4
	Franklin	July '40	23.00	113	546	41.9
	Gasconade	Aug. '40	23.00	56	301	45.2
	Gentry	July '40	23.00	57	259	30.3
	Greene	Nov. '40	23.00	90	410	39.0
	Grundy	Apr. '41	23.00	39	172	16.8
	Holt	June '40	23.00	66	286	52.4
	Iron	Oct. '40	23.00	75	395	59.1
	Johnson	Aug. '40	23.00	63	291	29.7
	Lawrence	Apr. '39	23.00	79	468	39.1
	Lewis	July '40	23.00	77	345	37.7
	Linn	Nov. '40	23.00	98	422	31.1
	Lincoln	May '40	23.00	57	230	27.9
	McDonald	May '40	23.00	17	84	10.7
	Macon	July '40	23.00	113	474	40.2
	Marion	Aug. '40	23.00	45	200	23.6

MEMBERSHIP
6-30-41

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Missouri (cont.)						
Physicians', Surgeons'	Monroe	July '40	$23.00	21	73	63.6
	Mississippi	Mar.'41	23.00	89	484	42.4
	Newton	July '40	23.00	93	440	43.3
	New Madrid	June '38	23.00	216	1108	67.7
	Osage	July '40	23.00	63	343	40.6
	Perry	Sept. '40	23.00	86	502	69.4
	Pettis	Nov. '38	23.00	50	217	20.6
	Pemiscot	Dec. '40	23.00	216	1408	36.9
	Pike	May '40	23.00	47	205	19.0
	Pulaski	Nov. '40	23.00	46	202	28.6
	Ralls	June '40	23.00	77	360	37.4
	Randolph	June '40	23.00	40	164	21.1
	Ripley	Feb. '41	23.00	103	474	52.5
	Saline	Apr. '40	23.00	33	131	17.1
	Scott	Sept. '40	23.00	64	357	44.4
	Shelby	July '40	23.00	91	379	75.2
	Stone	Apr. '39	23.00	57	260	33.5
	St. Clair	Apr. '40	23.00	40	141	18.0
	St. Francois	May '41	23.00	26	127	23.4
	St. Genevieve	May '40	23.00	32	158	29.4
	Texas, Dent	Mar.'41	23.00	44	191	23.4
	Vernon	Oct. '40	23.00	73	318	27.8
	Washington	Dec. '40	23.00	60	304	57.7
	Worth	July '40	23.00	28	104	20.0
Physicians' Individual basis	Camden	July '38	28.70	28	103	20.0
	Mercer	Apr. '38	25.23	8	48	2.7
	Miller	May '38	28.20	34	152	19.2
Physicians', Surgeons', Drugs	St. Charles	Jan. '41	26.00	42	304	24.1
Ohio - 40 units in 41 counties				2842	13,848	47.3
Physicians', Surgeons'	Adams	Apr. '40	25.68	86	399	44.3
	Ashland	Aug. '40	22.68	71	407	64.5
	Brown	Aug. '40	21.00	126	624	53.8
	Butler	July '40	22.20	63	290	47.4
	Carroll	Oct. '40	22.44	56	341	85.1
	Clinton	June '40	21.96	41	162	25.5
	Champaign	July '39	20.64	64	285	41.0
	Clark	June '40	20.00	48	210	43.2
	Defiance	Sept. '40	23.00	76	347	39.4
	Fairfield	Nov. '40	23.00	72	389	53.7

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Ohio (cont.)						
Physicians', Surgeons'	Fayette	Aug. '39	$21.48	40	177	52.6
	Geauga	Oct. '40	22.44	62	321	35.4
	Greene	Aug. '40	21.72	93	403	65.5
	Guernsey	Aug. '40	22.08	81	391	64.3
	Hardin	Mar. '39	22.20	87	412	46.5
	Henry	Jan. '41	20.88	43	210	45.7
	Highland	Oct. '40	20.00	79	365	45.1
	Hocking	Feb. '41	21.60	57	265	62.0
	Holmes	May '40	22.20	45	241	46.9
	Jackson, Vinton	July '40	21.96	86	498	42.6
	Lawrence	Aug. '40	21.96	65	366	50.0
	Logan	May '38	24.12	149	649	52.5
	Madison	July '40	22.34	46	226	43.8
	Medina	Aug. '40	21.84	42	193	52.0
	Meigs	Feb. '41	22.08	65	322	37.4
	Monroe	Aug. '40	22.08	92	455	61.7
	Morgan	May '40	25.56	37	174	48.1
	Muskingum	Aug. '40	22.44	72	341	61.0
	Perry	Apr. '39	21.96	91	514	53.2
	Pike	July '38	21.24	86	450	39.8
	Putnam	Jan. '41	20.88	60	307	53.1
	Richland	Nov. '40	22.08	72	343	55.0
	Ross	May '41	24.00	68	358	46.1
	Sandusky	Aug. '40	21.96	63	315	50.8
	Tuscarawas	Sept. '40	22.20	96	516	70.1
	Union	Jan. '41	21.72	85	365	43.6
	Warren	Apr. '40	21.72	105	485	47.7
	Wayne	Jan. '41	22.08	64	330	49.6
Physicians' Individual basis	Delaware	June '39	25.00	41	133	77.8
	Portage	June '38	26.75	67	269	25.9
Region IV - 77 units in 102 counties				7912	45,609	46.9
Kentucky - 3 units in 3 counties				277	1,582	19.6
Physicians' only	Knox	Dec. '39	14.76	109	621	16.8
	Morgan	May '40	13.44	38	212	9.7
Physicians', Surgeons', Hospital	Casey	May '40	15.70	130	749	35.1
North Carolina - 33 units in 38 counties				4362	26,144	59.4
Physicians' only	Alamance	July '40	16.80	89	576	52.0
	Bertie	Mar. '40	16.08	196	930	95.2
	Cabarrus, Davie Rowan	Feb. '40	14.52	117	696	42.1
	Caswell	June '39	12.12	180	1,227	86.6

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
North Carolina (cont.)						
Physicians' only	Chatham	Mar. '40	15.72	132	624	50.4
	Cleveland	July '40	17.40	147	898	68.7
	Cumberland	Oct. '39	17.76	112	660	73.8
	Duplin	Dec. '38	15.00	184	1,026	83.6
	Durham, Orange	May '40	13.08	200	959	44.4
	Forsyth	May '41	14.64	79	473	61.2
	Gates	Dec. '39	15.00	31	157	64.6
	Granville	May '40	15.96	205	1,264	60.8
	Guilford	Feb. '40	15.72	134	816	45.6
	Halifax	Apr. '39	17.52	222	1,400	93.7
	Henderson	July '40	13.32	98	495	60.1
	Hertford	July '40	15.72	57	308	42.5
	Hoke	Jan. '41	16.44	88	470	55.0
	Hyde	Feb. '40	15.48	145	745	96.0
	Jackson	June '40	13.20	47	237	23.5
	Johnston	Jan. '40	17.04	121	733	46.9
	Macon	Apr. '40	13.32	99	695	47.4
	Northampton	Feb. '39	15.60	157	981	91.8
	Person	June '39	15.36	226	1,464	59.3
	Pender	Apr. '40	15.00	53	278	42.7
	Randolph	Oct. '39	15.84	65	380	48.9
	Robeson	Jan. '39	22.00	374	2,906	59.4
	Sampson	July '39	15.96	94	603	33.2
	Stokes	Apr. '40	14.88	118	735	65.6
	Surry, Yadkin	Feb. '40	14.52	144	839	96.0
	Transylvania	Aug. '40	14.76	131	692	86.8
	Wake	May '40	18.00	69	345	23.0
	Warren	Apr. '40	15.12	146	1,022	74.5
Physicians', Surgeons', Hospital, Drugs	Tyrrell, Washington	Apr. '39	21.96	102	510	55.7
Tennessee - 17 units in 20 counties				1,508	7,721	55.2
Physicians' only	Claiborne	Dec. '40	14.28	130	488	39.9
	Decatur	Oct. '38	14.52	81	330	70.4
	Dickson	June '41	14.52	55	271	43.0
	Franklin	June '41	14.88	52	269	37.1
	Grainger	Sept. '38	15.48	94	624	41.8
	Henderson	July '39	18.48	81	430	45.3
	Jackson	Jan. '41	13.56	90	497	48.1
	Lincoln, Moore	May '41	14.96	74	362	37.6
	Marion	May '41	14.52	58	308	41.4
	McNairy	March '41	14.88	203	1,043	94.0
	White, Van Buren	March '41	15.00	113	578	59.5

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6-30-41 Families	 Persons	 Percent of eligible families
Tennessee (cont.)						
Physicians', Drugs	Cheatham	Apr. '41	$14.28	48	240	59.3
	Humphreys	Sept. '38	20.40	67	381	67.0
Physicians', Drugs, Dental	Hickman	Sept. '38	14.76	65	320	59.6
	Lewis, Perry	Sept. '38	14.28	101	506	91.0
	Stewart	Jan. '40	15.72	95	475	65.5
Physicians', Dental	Clay	March '40	15.00	101	549	71.6
Virginia - 17 units in 34 counties				1,359	8,073	32.9
Physicians', only	Botetourt	Aug. '40	16.92	31	181	20.3
	Greene, Madison, Page, Rappa- hannock, Rock- ingham	May '39	17.88	168	993	28.0
	Mecklenburg	Apr. '41	20.20	120	736	60.3
Physicians', Drugs	Lunenburg, Nottoway	July '39	19.60	85	493	54.5
Physicians', Drugs, Dental	Southampton	Apr. '40	26.52	51	318	42.1
Physicians', Surgeons', Hospital	Alleghany, Bath	Apr. '40	26.16	9	42	5.6
	Accomac	Jan. '39	19.68	154	797	58.3
	Essex, Gloucester, King & Queen King Williams Mathews Middlesex	Aug. '40	17.75	46	301	15.3
	Halifax	Apr. '39	24.72	70	418	28.0
	Henry, Patrick	Feb. '40	24.60	100	720	28.2
	Northampton	Feb. '39	19.88	43	200	52.4
Physicians', Hospitals	Buckingham, Cumberland	Aug. '40	18.00	59	295	28.8
	Charlotte	Apr. '40	20.88	57	376	32.8
	Charles City, James City New Kent Warwick York	Sept. '40	22.44	19	100	10.2
	Pittsylvania	July '39	22.08	66	426	28.3

M E M B E R S H I P
6-30-41

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Virginia (cont.)	Prince Edward	Apr. '40	$24.00	116	748	69.5
Physicians', Surgeons', Drugs, Hospital	Russell	Aug. '40	$26.00	165	929	31.3
West Virginia - 7 units in 7 counties				406	2,089	32.4
Physicians', Surgeons', Hospital	Braxton	Feb. '40	27.72	95	484	35.6
	Clay	Apr. '40	26.64	83	484	27.9
	Randolph	Apr. '40	21.24	71	325	41.8
	Taylor	March '40	19.08	22	101	21.6
	Upshur	May '40	23.88	42	231	28.2
	Wetzel	June '40	25.08	34	174	34.0
Physicians', Surgeons', Hospital, Drugs	Barbour	Jan. '40	25.20	59	290	34.9
Region V - 181 units in 187 counties				33,285	182,419	84.3
Alabama - 40 units in 40 counties				14,675	79,020	90.3
Physicians', Surgeons', Hospital, Drugs	Autauga	Apr. '41	17.00	130	650	30.4
	Barbour	Feb. '40	17.04	286	1,590	100.0
	Butler	May '38	15.96	493	2,937	57.1
	Calhoun	Jan. '40	15.48	231	1,293	93.9
	Cherokee	Jan. '41	17.50	97	563	90.6
	Chilton	June '39	15.36	342	1,843	97.1
	Choctaw	Oct. '38	15.20	628	3,281	100.0
	(C)Clarke	Apr. '40	15.12	324	1,685	100.0
	Cleburne	Jan. '40	16.38	128	640	97.0
	Colbert	Jan. '40	18.40	192	999	100.0
	(C)Conecuh	Mar. '41	14.64	95	547	21.3
	(C)Crenshaw	Jan. '41	15.60	214	950	80.5
	Dale	Feb. '40	18.40	176	920	97.2
	Dallas	Mar. '39	15.36	934	5,137	100.0
	DeKalb	May '40	18.40	159	827	85.5
	Etowah	Jan. '41	16.80	550	3,025	100.0
	Franklin	Jan. '39	16.20	624	2,500	100.0
	Greene	Jan. '40	16.92	816	4,000	100.0
	Henry	Jan. '40	16.32	176	983	94.6
	Houston	Feb. '39	18.12	243	1,280	84.1
	Lamar	Mar. '39	21.00	360	1,983	100.0
	Lauderdale	Jan. '39	19.44	350	1,915	100.0
	Lawrence	Feb. '40	19.20	207	1,159	93.7
	Lee	May '40	16.68	193	1,136	67.7
	Limestone	Jan. '40	19.27	488	2,575	100.0
	Lowndes	Feb. '40	20.40	394	2,049	97.5
	(C)Madison	Jan. '40	15.48	216	1,208	75.5

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Alabama (cont.)						
Physicians', Surgeons', Hospital, Drug	Marengo	Jan. '39	$17.16	752	4,973	100.0
	Marion	Jan. '39	17.28	704	3,802	100.0
	Monroe	June '39	18.80	351	1,393	100.0
	Morgan	Jan. '40	19.20	337	2,012	100.0
	Perry	Mar. '39	18.80	308	1,809	99.7
	Pickens	May '39	17.28	328	1,806	100.0
	(C)Pike	Feb. '41	16.56	219	1,097	89.0
	(C)St. Clair	Jan. '40	18.00	71	369	30.9
	Sumter	June '38	15.84	868	5,054	100.0
	Tallapoosa	Jan. '39	18.40	364	1,888	100.0
	(C)Wilcox	Jan. '38	17.64	973	5,513	100.0
	(C)Winston	Mar. '40	18.96	166	443	97.1
	Talladega	Jan. '41	16.56	138	681	81.2
Florida - 4 units in 6 counties				320	1,894	40.1
Physicians' only	Citrus, Hernando Pasco	Feb. '41	13.78	32	121	9.8
	Escambia	Apr. '39	15.06	60	348	68.2
Physicians', Surgeons', Hospital, Drugs	Madison	Apr. '39	16.32	122	833	55.2
Physicians', Drugs	Jefferson	Apr. '39	15.58	106	592	64.6
Georgia - 117 units in 121 counties				15,055	82,384	84.4
Physicians' only	Clayton	Mar. '39	15.24	55	312	83.3
	Fannin	Mar. '40	13.68	28	161	100.0
	Fayette	Jan. '39	15.60	138	843	74.6
	Miller	Feb. '39	15.36	60	351	88.2
	Murray	Jan. '39	11.20	119	619	90.2
	Paulding	Apr. '39	11.40	106	575	95.5
	Pike	Jan. '40	13.08	81	483	97.6
	Sumter	Apr. '41	12.60	14	68	14.9
	Towns	Jan. '39	10.80	32	154	74.4
	Union	Jan. '39	12.84	162	818	96.4
Physicians', Surgeons', Hospital	Berrien	Jan. '39	15.30	18	106	90.0
	Carroll	May '38	15.00	420	2,326	70.7
	Catoosa	Mar. '39	12.10	44	267	72.1
	Chattooga	Jan. '41	13.56	90	504	62.5
	Cobb	Jan. '41	16.80	61	262	37.9
	(C)Columbia	Jan. '39	15.60	201	1,175	90.5
	Colquitt	May '40	15.48	112	640	100.0
	Dawson	Apr. '39	11.30	106	562	100.0
	Douglas	Jan. '39	12.48	76	438	75.2
	Emanuel	Feb. '39	13.32	161	853	71.2
	Forsyth	Jan. '39	15.00	327	1,630	95.6

(C) - Capitation plan used in making payment for physicians' services.

MEMBERSHIP
6-30-41

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Georgia (cont.)						
Physicians', Surgeons', Hospital	Glascock, Warren	Jan. '39	$15.36	263	1,432	95.6
	Gwinnett	Jan. '39	15.36	188	1,075	87.0
	Hall	Mar. '39	15.50	162	900	93.1
	Haralson	Mar. '39	13.43	193	1,048	91.0
	Irwin	Jan. '39	13.70	55	315	100.0
	Jenkins	Jan. '39	15.60	173	975	82.8
	Liberty, Long Tattnall	May '39	15.12	223	1,108	94.9
	Lincoln	Mar. '39	15.70	64	365	100.0
	Lumpkin	Apr. '39	10.17	86	438	100.0
	Madison	Feb. '39	13.68	391	1,892	100.0
	Polk	Apr. '39	13.32	104	580	75.3
	(C)Taylor	Apr. '39	14.88	114	648	81.4
	Walker	Jan. '39	13.32	130	705	80.2
	Whitfield	Jan. '39	13.00	110	550	80.9
Physicians', Surgeons', Hospital Drugs	(C)Appling	Jan. '41	15.00	208	1,081	68.4
	Baker	Jan. '39	15.72	62	351	78.5
	Baldwin	Jan. '39	16.34	92	584	94.8
	Bulloch	Mar. '39	15.72	171	1,050	81.8
	Brooks	Jan. '39	15.72	153	914	82.7
	Burke	Jan. '39	15.72	163	964	93.3
	Candler	July '38	16.56	138	681	81.2
	Chattahoochee	Apr. '40	13.56	41	228	97.6
	Clarke	May '39	15.00	55	262	98.2
	Clay, Early	Jan. '40	14.88	53	287	91.4
	Clay	July '38	15.00	149	793	100.0
	Crawford	June '39	13.50	132	727	97.1
	(C)Crisp	Mar. '41	15.00	64	321	50.4
	Decatur	Jan. '39	15.49	131	720	78.4
	Dodge	Mar. '39	15.60	196	1,107	79.7
	Dougherty	Jan. '39	15.26	64	337	87.7
	Early	Jan. '40	15.00	95	596	71.9
	Franklin	Feb. '39	15.96	250	1,340	67.6
	Grady, (Wolf Creek)	Jan. '39	14.88	100	505	84.0
	Greene	Mar. '38	15.84	487	2,625	94.4
	Hancock	Jan. '39	14.76	102	530	98.1
	(C)Hart	Feb. '39	15.24	217	1,211	55.1
	Heard	Jan. '39	13.28	188	993	92.2
	Houston	Feb. '39	15.90	125	740	91.2
	Jasper	Jan. '39	15.20	130	681	95.5
	Jeff Davis	Apr. '41	14.38	60	337	58.3
	Laurens	Apr. '39	15.46	505	2,761	100.0
	(C)Lee	Jan. '39	14.64	122	680	90.4

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Georgia (cont.)						
Physicians', Surgeons', Hospital, Drugs	Lowndes	May '40	$13.60	114	411	100.0
	Macon	Jan. '40	14.52	181	942	67.3
	McDuffie	Apr. '40	13.92	120	611	100.0
	Meriwether	Mar. '39	15.72	192	1,086	86.9
	Morgan	Jan. '39	14.88	160	858	100.0
	Newton	Mar. '39	15.72	93	378	78.8
	Oconee	Jan. '39	15.48	84	402	94.4
	Oglethorpe	Feb. '39	15.00	220	1,260	90.9
	Peach	Feb. '39	15.70	109	623	95.6
	Putnam	Jan. '39	15.04	73	369	82.9
	Quitman	Jan. '39	15.42	76	488	90.5
	Stewart	Jan. '39	15.24	83	480	87.4
	Taliaferro	Jan. '39	15.36	302	1,771	93.2
	(C)Terrell	Jan. '39	15.00	136	680	77.3
	Thomas	Mar. '39	15.72	50	313	87.7
	(C)Toombs	Mar. '39	15.24	178	933	79.8
	Troup	May '39	13.57	180	1,002	88.7
	Twiggs	Apr. '39	15.95	167	995	94.4
	Walton	Feb. '39	14.26	90	447	87.4
	Washington	Jan. '39	15.60	315	1,906	93.2
	Wayne	Jan. '41	14.04	43	223	40.2
	Webster	Jan. '39	15.12	25	134	64.1
	Wilcox	Apr. '39	15.36	131	743	82.4
	Wilkes, Lincoln	Mar. '39	14.28	172	986	98.8
	Wilkinson	Feb. '39	13.08	91	480	71.1
	Worth	Jan. '39	15.50	183	1,008	79.2
Physicians', Surgeons', Hospital, Drugs, Dentists'	Habersham	Jan. '37	19.80	125	763	100.0
	Harris	Apr. '36	19.80	122	713	70.5
	Rabun	Mar. '39	16.00	75	451	93.6
	Seminole	Jan. '39	16.44	61	328	85.9
Physicians', Surgeons', Hospital, Dentists'	Banks	Feb. '39	15.91	201	1,189	93.9
	Coweta	Mar. '39	12.24	67	342	47.9
	Randolph	Jan. '39	16.00	217	1,311	100.0
	Stephens	Feb. '39	15.00	133	678	100.0
Physicians', Drugs, Dentists'	DeKalb	Mar. '39	15.34	76	418	88.4
	(C)Rockdale	Jan. '39	14.04	76	395	94.9
Physicians', Drugs	Bleckley	Feb. '39	15.48	75	425	75.0
	Bibb	May '39	14.88	48	254	90.6
	(C)Brantley, Pierce	Mar. '41	16.56	28	186	66.7
	Butts	Mar. '40	15.14	107	551	93.0
	Calhoun	Jan. '39	15.00	74	371	88.1

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6-30-41 Families	 Persons	Percent of eligible families
Georgia (cont.)						
Physicians', Drugs	Dade	Jan. '39	$11.90	75	440	93.7
	Dooly	Jan. '41	14.64	173	684	77.6
	Henry	Mar. '39	15.12	84	453	92.3
	Jones	May '39	14.88	46	269	92.0
	Lamar	Feb. '39	12.60	94	546	92.1
	Marion	Jan. '39	13.92	33	199	91.7
	(C)Montgomery	Mar. '40	15.24	95	572	95.0
	Pickens	July '38	11.90	165	986	75.7
	Schley	Feb. '39	14.16	31	162	66.9
	Screven	Jan. '40	15.52	65	359	70.6
	Talbot	Mar. '39	15.60	74	421	87.1
	(C)Treutlen	May '41	15.26	60	316	88.2
	(C)Wheeler	May '41	15.26	82	432	92.1
South Carolina - 20 units in 20 counties				3,235	19,121	70.8
Physicians' only	(C)Clarendon	Mar. '39	16.54	202	1,321	40.1
	Williamsburg	Jan. '39	15.99	222	1,332	71.2
Physicians', Surgeons', Hospital	Allendale	Mar. '39	15.60	256	1,411	80.5
	Fairfield	Mar. '40	16.22	78	540	36.3
	(C)Jasper	Mar. '39	15.50	107	606	69.0
	McCormick	Mar. '40	15.12	84	515	65.1
Physicians', Surgeons', Hospital, Drugs	Abbeville	Mar. '39	15.60	105	614	34.0
	Berkeley	May '40	15.72	67	348	74.3
	Chester	Feb. '39	16.27	198	1,243	98.5
	Edgefield	Feb. '39	15.50	252	1,260	84.6
	(C)Newberry	Apr. '41	15.17	137	730	55.5
	Union	Jan. '39	17.04	260	1,581	84.1
Physicians', Surgeons', Hospital, Drugs Dentists'	Greenwood	Apr. '39	15.24	115	611	87.1
Physicians', Drugs	Bamberg	Mar. '39	15.60	152	760	71.7
	(C)Chesterfield	Apr. '39	15.84	132	790	73.3
	Laurens	Jan. '39	15.36	207	1,247	76.9
	(C)Marlboro	Apr. '41	15.12	41	212	34.4
	Pickens	Apr. '39	15.90	166	995	76.1
Surgeons', Hospital	Darlington	May '41	5.00	200	1,262	76.9
	York	Apr. '41	3.00	254	1,743	85.8

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Region VI - 146 units in 148 counties				29,372	149,434	66.9
Arkansas - 60 units in 59 counties				11,624	57,214	66.7
Physicians' only	Cross, St. Francis	Feb. '38	$19.20	234	941	59.8
Physicians', Surgeons', Hospital	Arkansas	Mar. '37	13.90	174	691	66.2
	Baxter	Mar. '38	14.90	126	626	64.0
	Benton	Jan. '39	14.88	203	1,054	41.9
	(C)Bradley	Jan. '38	17.00	272	1,360	92.5
	Carroll	June '38	15.12	141	577	58.3
	Chicot	May '41	24.00	136	676	45.0
	Cleveland	Jan. '38	15.12	248	1,250	84.4
	Columbia	Apr. '38	14.38	242	1,247	79.3
	Conway	May '39	14.04	331	1,622	76.1
	Crittenden	Mar. '39	21.60	116	537	66.3
	Cross, Crittenden	Mar. '40	16.44	288	1,283	100.0
	Desha, Drew	Apr. '41	17.64	443	2,045	94.3
	Drew	May '39	16.80	149	741	75.6
	Garland	Feb. '39	15.72	86	434	66.7
	(C)Greene	Mar. '38	13.32	300	1,500	54.2
	Hempstead	Mar. '39	15.72	326	1,685	57.9
	Jackson	Mar. '38	13.68	278	1,442	71.8
	Johnson	Oct. '39	14.28	96	502	63.4
	Lafayette	Mar. '39	15.12	214	1,118	68.4
	Lee	Feb. '38	17.16	159	871	60.7
	Logan	May '40	14.76	143	738	44.8
	Monroe	Feb. '38	16.92	247	1,244	82.3
	Mississippi	Jan. '40	23.00	141	776	100.0
	Nevada	Jan. '38	14.76	293	1,564	77.5
	Ouachita	Mar. '38	15.36	229	1,314	81.2
	Phillips	May '36	16.56	234	1,368	72.3
	Pike	Mar. '38	16.80	268	1,358	69.6
	Pulaski	Feb. '41	15.20	34	212	97.1
	Searcy	Apr. '38	13.20	103	534	42.9
	Scott	Mar. '40	13.80	230	1,111	69.5
	Stone	Feb. '38	15.24	127	654	36.3
	VanBuren	Mar. '38	12.12	209	1,075	69.7
	Washington, Benton	Feb. '39	14.04	123	614	40.7
	Woodruff	Mar. '39	17.88	108	510	61.0
Physicians', Hospitals	Ashley	Apr. '38	14.16	196	949	68.1
	Calhoun	Jan. '37	17.28	277	840	100.0
	Clark	Mar. '38	16.44	222	1,203	62.1
	Crawford	Mar. '39	14.76	69	343	43.7
	Cleburne	Jan. '37	12.30	202	1,005	61.0
	Dallas	Feb. '39	15.24	215	1,114	67.2
	Franklin	Apr. '40	12.36	118	624	52.9
	Fulton	May '38	14.10	68	351	28.8

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Arkansas (cont.)						
Physicians', Hospitals	Grant	Feb. '38	$17.64	102	542	61.8
	Howard	Mar. '38	13.40	279	1,228	75.4
	Izard	Mar. '38	15.00	128	653	57.9
	Lawrence	Mar. '39	12.12	191	702	74.3
	Little River	Mar. '38	15.12	415	1,868	92.2
	Marion	July '37	12.00	53	316	
	Perry	Mar. '38	15.00	151	728	76.6
	Poinsett	May '41	21.96	106	585	80.9
	Pope	June '38	15.36	178	964	53.5
	Pulaski	July '39	17.40	106	573	54.4
	Saline	Feb. '38	13.08	150	822	100.0
	Sebastian	Mar. '39	13.28	84	399	55.3
	Sharp	May '37	17.52	166	797	58.2
Physicians', Surgeons', Hospital, Drugs, Dentists'	Jefferson	June '36	14.88	206	1,099	69.6
Physicians' Surgeons, Hospital, Drugs	Montgomery	Mar. '38	15.84	256	1,164	69.8
Physicians', Surgeons', Hospital, Dentists'	Yell	Mar. '39	15.40	356	1,937	66.3
Physicians', Hospitals, Drugs	Miller	June '38	16.00	229	1,129	70.5
Louisiana - 30 units in 30 counties				6,046	30,569	55.9
Physicians' only	Avoyelles	Apr. '39	15.00	163	828	22.1
	Beauregard	June '41	15.00	46	161	100.0
	Bienville	Apr. '41	15.00	114	557	33.2
	De Soto	Apr. '40	15.12	346	1,791	100.0
	E. Carroll	Apr. '40	14.64	246	1,090	45.9
	Evangeline	Apr. '40	17.52	77	406	25.1
	Grant	Mar. '40	17.64	129	711	65.5
	Iberia	May '41	15.60	40	241	100.0
	Lafayette	May '39	15.53	204	1,128	68.0
	Lincoln	Apr. '41	14.88	287	1,543	47.3
	Morehouse	Mar. '40	14.88	255	1,235	45.0
	Natchitoches	July '39	15.60	340	1,646	73.1
	Ouachita	Apr. '40	18.00	232	1,190	61.4
	Sabine	Jan. '40	15.48	183	1,009	53.8
	St. Martin	June '39	15.40	163	881	44.0
	Tangipahoa	Mar. '41	14.64	191	925	58.4

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6-30-41 Families	Persons	Percent of eligible families
Louisiana (cont.)						
Physicians' only	Tensas	June '41	$14.88	257	1,296	65.9
	Webster	Mar. '39	18.24	285	1,428	88.2
	W. Carroll	Apr. '40	14.76	423	2,158	39.0
	Winn	Mar. '40	12.12	254	1,260	100.0
Physicians', Surgeons', Hospital	Allen	June '41	15.36	154	741	72.3
	Catahoula	Apr. '41	16.68	195	1,003	65.0
	Jackson	Mar. '40	15.96	151	776	55.9
Physicians', Drugs	Bossier	May '40	18.00	69	345	45.7
	E. Feliciana	Jan. '40	15.24	131	756	44.3
	LaSalle	Mar. '40	17.28	18	88	28.1
	Madison	Mar. '39	14.16	253	1,296	81.9
	Pointe Coupee	Jan. '40	14.76	469	2,074	75.6
	Red River	Jan. '40	16.56	301	1,548	91.5
	(C)St. Helena	July '39	16.92	70	408	15.3
Mississippi - 56 units in 59 counties				11,702	61,651	74.6
Physicians' only	Hancock, Pearl River	Jan. '40	16.56	80	469	37.6
	(C)Jasper	Mar. '41	13.00	300	1,500	85.7
	(C)Leake	Jan. '33	20.76	232	1,644	74.2
	Tippah	Jan. '39	20.04	240	1,120	80.0
Physicians', Surgeons', Hospital, Drugs	Oktibbeha	May '41	19.44	116	671	73.0
	Pike	Aug. '39	25.00	382	2,292	100.0
Physicians', Surgeons', Hospital, Dentists'	Lowndes	Jan. '39	16.56	360	1,800	97.3
Physicians', Surgeons', Drugs	Issaquena, Sharkey	Apr. '39	24.00	130	662	75.1
Physicians', Drugs	Adams	July '38	15.96	255	1,350	99.2
	(C)Alcorn	Jan. '41	18.00	151	755	75.5
	Attala	Jan. '41	17.04	276	1,380	100.0
	(C)Bolivar	Mar. '41	17.52	55	271	100.0
	Carroll	Mar. '36	17.04	365	1,646	94.6
	Chickasaw	Jan. '41	20.64	282	1,538	84.2
	(C)Choctaw	Jan. '41	15.24	130	770	53.5
	Claiborne	Feb. '39	18.00	118	625	100.0
	(C)Clarke	May '37	19.68	127	634	50.8
	Clay	Jan. '41	18.24	269	1,340	61.0
	Covington	Mar. '39	15.24	228	1,185	50.1
	De Soto	Jan. '40	17.52	46	226	47.4
	Forrest	Mar. '39	23.88	94	485	42.5

(C) - Capitation plan used in making payment for physicians' services.

MEMBERSHIP
6-30-41

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Mississippi (cont.)						
Physicians', Drugs	Grenada	Apr. '39	$21.96	218	1,162	56.5
	George, Jackson	June '41	19.43	14	79	
	Hinds	May '40	20.00	60	300	100.0
	Holmes	Apr. '39	17.16	334	2,001	100.0
	Jeff. Davis	July '38	14.40	390	2,137	79.9
	Jefferson	Mar. '39	16.80	337	1,776	95.2
	Jones	Feb. '39	15.00	218	1,223	97.9
	(C)Kemper	Feb. '41	17.76	171	982	63.6
	Lee	Jan. '40	15.00	322	1,602	74.7
	Madison	Jan. '40	15.20	372	2,610	84.4
	(C)Montgomery	Apr. '41	16.70	100	579	54.9
	(C)Neshoba	Apr. '41	16.08	252	1,366	76.6
	(C)Newton	Jan. '41	13.92	206	1,140	78.6
	Noxubee	Mar. '41	15.48	449	1,804	100.0
	Panola	May '39	20.16	148	796	64.6
	Pontotoc	July '40	17.00	166	732	42.0
	Prentiss	Mar. '41	17.88	158	737	100.0
	Quitman	Apr. '41	14.52	115	535	91.3
	Smith	Jan. '36	20.00	441	2,205	100.0
	(C)Scott	Feb. '41	16.20	294	1,617	32.8
	(C)Simpson	July '38	17.88	238	1,293	75.1
	Tate	Mar. '39	14.23	84	585	56.8
	Tishomingo	Jan. '40	18.00	182	1,035	51.1
	Tallahatchie	Mar. '39	19.80	131	970	80.8
	Union	June '40	19.00	156	802	62.1
	Walthall	July '38	18.60	265	1,378	72.6
	Wayne	Mar. '39	21.36	222	1,167	46.7
	(C)Washington	Mar. '41	16.32	118	632	64.5
	(C)Webster	May '41	12.00	226	1,141	77.1
	(C)Winston	Jan. '38	19.56	135	1,052	81.1
	(C)Yalobusha	May '41	18.00	182	859	100.0
Physicians', Drugs, Dental	Franklin	Jan. '39	22.56	284	1,478	56.2
Physicians', Surgeons'	Itawamba	Feb. '39	15.00	152	761	95.6
	Rankin	July '39	20.00	91	470	25.7
	Wilkinson	July '38	18.00	35	182	100.0
Region VII - 53 units in 85 counties				7,479	37,696	55.6
Kansas - 24 units in 28 counties				2,970	14,919	56.9
Physicians', Surgeons', Hospital, Drugs, Dentists'	Allen	June '41	30.00	64	312	46.7
	Cheyenne	Oct. '39	33.00	95	510	50.0
	Cloud	May '40	30.00	89	469	61.9
	Coffey	May '40	30.00	151	755	50.3
	Decatur	July '39	33.00	197	955	52.5
	Ellis	Sept. '39	33.00	100	731	84.0
	Graham	July '39	33.00	217	1,202	55.6

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6-30-41 Families	Persons	Percent of eligible families
Kansas (cont.)						
Physicians', Surgeons', Hospital, Drugs, Dentists'	Harper, Kingman Pratt Reno	May '40	$30.00	67	335	55.8
	Jewell	Mar. '40	30.00	223	1,027	57.2
	Lincoln	May '40	30.00	103	539	69.1
	Norton	July '39	33.00	243	1,023	54.0
	Osage	July '40	30.00	81	402	51.3
	Phillips	July '39	30.00	231	1,123	57.0
	Rawlins	Oct. '39	33.00	79	386	46.7
	Republic	Jan. '40	30.00	84	370	64.8
	Rooks	July '39	30.00	150	796	54.5
	Russell	Apr. '40	33.00	44	254	57.9
	Rush	Oct. '40	30.00	40	255	70.2
	Smith	July '39	33.00	277	1,274	79.1
	Shawnee, Wabaunsee	Sept. '40	30.00	63	343	56.3
	Trego	Sept. '39	33.00	62	328	52.1
Physicians', Surgeons', Hospital, Dentists'	Chatauqua	June '40	30.00	73	361	42.2
	Linn	May '40	30.00	139	652	48.8
	Osborne	Feb. '40	30.00	107	510	82.9
Nebraska - 23 units in 43 counties				4,002	20,473	54.9
Physicians', Surgeons', Hospital, Drugs, Dentists'	Boyd, Holt	Mar. '40	33.00	160	832	69.4
	Boone	Jan. '40	30.00	315	1,565	65.6
	Brown, Keyapaha Rock	May '41	33.00	99	539	39.0
	Box, Butte Grant Sheridan (So.)	Jan. '40	30.00	106	527	32.6
	Banner, Scotts Bluff Morrill Sioux (So.)	Feb. '40	30.00	93	465	41.4
	Butler	May '40	30.00	116	545	60.5
	Cherry (We.) Sheridan (No.)	June '40	30.00	96	503	100.0
	Cheyenne, Deuel Kimball	Aug. '40	30.00	103	500	51.5
	Custer	Sept. '39	30.00	413	2,137	65.3
	Dawes, Sioux (No.)	July '40	30.00	62	312	51.9
	Dawes	July '40	30.00	66	341	66.0
	Dawson	Jan. '40	30.00	140	696	73.3
	Fillmore	Dec. '39	30.00	76	363	30.2
	Garfield Valley Loup	Jan. '40	30.00	275	1,332	100.0

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6-30-41 Families	 Persons	 Percent of eligible families
Nebraska (cont.)						
Physicians', Surgeons', Hospital, Drugs, Dentists'	Greeley, Wheeler	Apr. '41	$30.00	108	648	91.1
	Hamilton	June '41	33.00	100	415	49.5
	Hitchcock, Hayes	July '40	30.00	87	452	33.8
	Howard	Oct. '39	30.00	163	857	15.0
	Knox	July '39	33.00	222	1,288	73.5
	Nuckolls	Feb. '40	30.00	108	545	39.4
	Pawnee	July '39	33.00	97	472	50.0
	Platte	Aug. '39	30.00	116	572	72.9
	Polk	Aug. '39	30.00	137	646	55.1
	Saunders	Jan. '40	30.00	107	573	68.1
	Seward	Dec. '39	30.00	141	631	36.6
	Sherman	Dec. '39	30.00	215	1,139	73.6
	Webster	Dec. '39	33.00	107	537	31.5
	York	Apr. '40	33.00	175	761	42.9
South Dakota - 1 unit in 14 counties				501	2,304	53.0
Physicians', Surgeons', Hospital, Drugs, Dentists'	Armstrong, Dewey, Hughes, Hyde, Haakon, Jackson, Jones, Lyman, Mellette, Potter, Stanley, Sully, Washabaugh, Ziebach	Apr. '41	33.00	501	2,304	53.0
Region VIII - 48 units in 49 counties				5,365	29,699	49.6
Oklahoma - 22 units in 22 counties				3,283	16,559	47.2
Physicians', only	Wagoner	July '38	16.30	76	395	31.3
Physicians', Surgeons', Hospital	Beckham	May '38	23.28	125	723	30.0
	Caddo	Feb. '39	24.48	170	754	43.3
Physicians', Surgeons', Hospital, Drugs	Comanche	July '38	24.24	247	1,200	36.1
	Love	July '39	22.56	135	759	76.7
	Roger Mills	May '38	25.80	114	588	22.0

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Oklahoma (cont.)						
Physicians',	Creek	Aug. '39	$25.20	93	505	27.9
Surgeons', Hos-	Grady	July '38	25.00	287	1,538	56.5
pital, Drugs,	Le Flore	Sept. '40	25.00	167	653	50.6
Dentists'	Murray	Apr. '38	23.76	51	264	38.3
Physicians',	Ellis	Apr. '40	24.36	76	366	36.7
Surgeons',	Jackson	Apr. '39	28.80	223	1,042	53.0
Hospital,	Pawnee	July '40	25,68	177	389	41.9
Dentists'	Pontotoc	Aug. '39	23.16	192	912	52.7
	Woods	Nov. '40	22.86	151	734	42.7
Physicians',	Pittsburg	Apr. '39	14.76	113	604	68.1
Surgeons',						
Drugs						
Physicians',	Carter	July '39	25.00	182	1,018	48.0
Hospital,	Latimer	June '39	15.00	153	750	55.0
Dentists'	McCurtain	June '40	14.00	243	1,237	51.1
Physicians',	Atoka	Sept. '40	17.76	113	585	44.1
Drugs,	Nowata	Oct. '39	18.96	82	434	50.9
Dentists'	Pushmataha	June '39	23.16	113	599	66.5
Texas - 26 units in 27 counties				2,582	13,140	46.4
Physicians'	Camp	Apr. '39	19.08	56	295	28.9
only	Nacogdoches	Apr. '39	17.16	95	523	69.4
	VanZandt	Apr. '41	20.52	152	706	52.9
Physicians',	Nolan	Mar. '40	21.24	84	355	34.0
Surgeons'	Hidalgo	July '39	18.33	30	160	13.8
Physicians',	Dickens, Kent	May '40	25.08	101	478	83.5
Surgeons',	Jasper	June '39	16.80	49	285	100.0
Hospital	Jones	May '40	19.44	77	377	26.8
	Newton	June '40	15.48	62	374	100.0
Physicians',	Atascosa	Apr. '39	24.36	74	348	41.1
Surgeons', Hos-	Bowie	July '40	17.96	138	821	56.8
pital, Drugs	Frio	Apr. '40	24.84	39	191	33.3
Physicians',	Cameron	Nov. '39	24.96	58	293	31.5
Surgeons', Hos-	Falls	Mar. '39	24.12	99	509	68.8
pitals, Drugs,	Hamilton	Feb. '39	25.44	38	177	27.9
Dentists'	Hill	Apr. '39	26.00	191	1,291	94.6
	Limestone	Feb. '39	17.76	188	930	76.7

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Texas (cont.)						
Physicians', Surgeons', Dentists'	Grayson	Dec. '40	$19.56	126	645	38.7
	Leon	Apr. '41	21.00	49	252	46.2
	Scurry	Nov. '39	22.68	49	206	43.4
Physicians', Surgeons', Hospital, Dentists'	Fisher	Aug. '40	22.80	105	498	48.4
	Freestone	Feb. '40	22.20	89	412	48.9
	Hopkins	Jan. '41	30.00	181	821	85.8
	Taylor	Aug. '39	21.60	160	749	44.7
	Willacy	June '39	30.00	69	345	53.1
Physicians', Dentists'	Upshur	May '38	14.88	221	1,099	72.2
Region IX - 10 units in 16 counties				1,672	8,795	55.5
California - 3 units in 7 counties				264	1,108	70.4
Physicians', Surgeons', Hospital, Drugs	Butte	June '41	48.04	119	471	74.1
	Lake, Mendocino Sonoma	June '41	50.27	70	322	70.0
	Monterey, San Benito Santa Cruz	June '41	48.43	75	315	71.0
Utah - 7 units in 9 counties				1,408	7,687	52.0
Physicians', Surgeons'	(C)Wayne	Jan. '40	25.00	284	1,540	46.6
Physicians', Surgeons', Hospital	Grand	Apr. '38	35.00	86	409	36.8
	(C)San Juan	July '38	40.00	241	1,245	59.1
Physicians', Surgeons', Hospital, Drugs	Box Elder	Jan. '40	30.00	264	1,462	53.5
	Duchesne, Uintah	June '41	30.00	268	1,483	49.6
	Juab	July '40	30.00	87	469	62.1
Physicians', Surgeons', Hospitals, Drugs, Dentists'	Utah, Wasatch	July '40	30.00	178	1,079	48.9

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Region X - 22 units in 43 counties				3,260	16,364	43.2
Colorado - 6 units in 7 counties				606	3,067	53.8
Physicians', Surgeons', Hospital, Drugs, Dentists'	Delta	Oct. '39	$35.64	95	475	37.1
Physicians', Surgeons', Hospital	Custer, Fremont	June '41	33.60	67	291	44.0
	Larimer	Apr. '39	33.96	190	914	72.5
	Weld	Dec. '38	34.32	114	703	71.3
	Yuma	June '41	35.64	62	333	32.6
Physicians', Surgeons'	Phillips	Jan. '41	34.44	78	351	73.6
Montana - 11 units in 30 counties				2,209	11,034	39.0
Physicians', Surgeons'	Big Horn, Carbon Stillwater Yellowstone	Aug. '40	30.00	275	1,473	40.8
	Blaine	May '41	30.00	31	181	31.4
	Cascade	Aug. '40	30.00	122	519	38.5
	Carter, Garfield Custer Dawson Fallon Mc Cone Powder River Prairie Richland Rosebud Treasure Wibaux	July '40	30.00	829	4,226	31.7
	Chouteau	Aug. '40	30.00	200	766	79.2
	Flathead	Dec. '40	30.00	206	1,005	48.0
	Glacier, Pondera Toole	Sept. '40	30.00	106	540	55.9
	Hill, Liberty	Aug. '40	30.00	152	830	75.0
	Lake	Nov. '40	30.00	91	458	50.3
	Park, Sweet Grass	Sept. '40	30.00	87	420	58.4
Physicians', Surgeons', Hospital Dental	(C) Cascade, Lewis and Clark Teton	Nov. '33	50.00	110	616	34.1

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6-30-41 Families	 Persons	Percent of eligible families
Wyoming - 5 units in 6 counties				445	2,263	53.5
Physicians', (C) Surgeons', Hospital	Lincoln (part of Caribou Co., Idaho)	June '41	$35.00	58	331	41.4
	Niobrara	Sept. '39	30.00	76	406	46.5
Physicians', (C) Surgeons', Hospital, Drugs (C)	Converse	Aug. '39	30.00	116	553	67.1
	Platte	June '40	30.00	108	547	48.0
	Weston	July '39	30.00	87	426	66.1
Region XI - 8 units in 11 counties				868	4,205	45.3
Idaho - 4 units in 5 counties				537	2,736	51.4
Physicians', Surgeons', Hospital, Drugs	Bingham	June '41	37.00	231	1,186	67.3
	Boise, Gem	Jan. '41	40.00	107	457	42.0
Physicians', Surgeons', Hospital, Drugs, Dentists'	Bear Lake	May '40	41.00	117	628	51.5
	Franklin	Sept. '40	31.00	82	465	37.3
Washington - 4 units in 6 counties				331	1,469	38.3
Physicians', Surgeons', Hospital, Drugs	Benton, Franklin	July '40	30.10	78	326	58.2
	Ferry, Stevens	Mar. '41	30.25	73	372	34.8
	Yakima	Nov. '40	31.00	135	580	46.1
Physicians', Surgeons', Hospital, Drugs, Dentists'	Okanogan	Nov. '40	30.00	45	191	19.7
Region XII - 36 units in 78 counties				5,395	27,112	56.3
Colorado - 5 units in 6 counties				410	1,952	34.6
Physicians', Surgeons'	Otero	June '40	20.00	117	578	43.0
Physicians', Surgeons', Hospital, Drugs, Dentists'	Bent	July '40	30.00	80	347	56.5
	Elbert, El Paso	June '41	30.00	112	532	28.7
	Kiowa	July '39	30.00	60	278	38.7
	Crowley	June '41	30.00	41	217	21.0
Kansas - 6 units in 27 counties				754	3,397	41.9
Physicians', Surgeons', Hospital	Gove, Logan	June '39	26.00	96	463	29.1
	Kearny	May '40	25.00	21	110	42.9

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Kansas (cont.)						
Physicians', Surgeons', Hospital	Sheridan, Thomas	June '39	$26.00	87	383	20.1
	Sherman, Wallace	June '39	26.00	128	568	40.0
Physicians', Surgeons', Hospital, Dentists'	Clark, Finney, Ford, Grant, Gray, Greeley, Haskell, Hodgeman, Lane, Meade, Morton, Scott, Stanton, Stevens, Seward, Wichita	May '39	35.00	391	1,668	52.1
	Beaver, Oklahoma Cimarron, " Texas, "					
	(C)Ness	May '39	28.00	31	205	22.6
New Mexico - 12 units in 20 counties				2,441	13,340	67.6
Physicians', Surgeons'	Curry	Feb. '39	25.00	72	346	68.6
	Roosevelt	Apr. '40	20.00	135	652	45.3
Physicians', Surgeons', Hospital	DeBaca	Feb. '39	19.92	36	183	57.1
	Lincoln	Mar. '39	25.56	18	102	24.7
	Otero	Apr. '39	23.40	22	93	37.3
Physicians', Surgeons', Hospital, Drugs	Colfax, Harding, Union	June '40	28.00	34	143	19.7
	Bernalillo, Santa Fe, Sandoval, Socorro, Torrance, Valencia	July '39	28.00	1,548	8,280	100.0
	Grant	May '39	20.00	9	33	11.3
	Guadalupe	Mar. '40	28.00	47	313	23.5
	Mora, San Miguel	Mar. '39	28.00	237	1,520	43.6

(C) - Capitation plan used in making payment for physicians' services.

Region, State Type of Service		County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
New Mexico (cont.)							
Physicians', Surgeons', Hospital, Drugs		Rio Arriba, Santa Fe	Mar. '40	$28.00	163	1,019	47.9
		Taos	May '40	28.00	120	651	66.7
Oklahoma - 3 counties in Kansas unit							
Texas - 13 units in 25 counties					1,790	8,423	56.0
Physicians', Surgeons', Hospital		Bailey	July '38	21.36	138	654	100.0
		Briscoe Hale Swisher	May '41	27.00	131	636	27.3
		Castro Deaf Smith Parmer	Sept. '39	28.00	126	592	38.7
		Childress	Sept. '39	26.16	158	682	100.0
	(C)	Collingsworth	June '38	25.92	119	610	94.4
		Cochran Hockley	July '38	26.64	212	1,060	52.2
		Cottle	Aug. '38	26.04	150	670	90.3
		Dallam Hartley Moore Sherman	Oct. '38	26.40	179	818	36.7
		Donley Hall	July '38	26.52	245	1,163	73.8
		Hemphill	Aug. '39	26.00	30	149	48.4
		Lamb	July '38	24.72	108	502	58.7
Physicians', Surgeons', Hospital, Drugs		Hansford Lipscomb Ochiltree	Dec. '39	26.00	45	201	27.1
	(C)	Gray Wheeler	Sept. '39	28.00	149	686	90.2

(C) - Capitation plan used in making payment for physicians' services.

DENTAL CARE PROGRAM FOR FSA BORROWERS

Local FSA supervisors and the families with whom they are working may not be fully aware of the intimate relation between dental and general health. They may not cite diseased teeth and diseased oral tissues as factors related to systemic disease. But from both supervisors and families have come insistent demands that something be done about the all too obvious effects of neglect of dental needs. It is not unusual for the farmers or their wives, when questioned about their health needs, to place dental care at the top of the list as their most urgent need — dental care and some way of getting it at a cost they can afford.

The problem of providing dental care of even minimal adequacy for these families with their limited financial resources is a staggering one. The problem differs in many respects from that of providing reasonably adequate medical care. The accumulation and neglect of dental disease are virtually universal among these disadvantaged families. Even if accumulated defects could be dealt with, a very expensive undertaking at best, there would still be a steady, almost mathematical incidence of dental caries. Herein lies a significant difference between medical and dental needs. A family can "insure" its members against the high cost of unexpected illness, but it must purchase year by year that dental care which is mathematically certain to be required.

If accumulated dental defects could be eliminated, and restorative dentistry essential to general health could be performed, the cost of maintaining the teeth and oral tissues in a state of health would be within the reach of most farm families. This approach, possible only through intensive education and heroic financing, would be ideal if it were feasible. This same general approach, whittled down to irreducible essentials, has been given a very limited and inconclusive trial in the FSA program. At the end of the fiscal year, a dental care plan designed with this approach in view had all but bogged down, lacking the solid foundation of organized dental health education and of adequate, practicable financing.

Without dismissing this ideal approach to the problem, one deserving further trial, let us consider another long-range approach. If protective dentistry were available to each three-year-old, and if the child were to receive periodic care from year to year, he and his fellows could be kept indefinitely in a state of dental health at very reasonable cost. If to this basic preventive program for children be added extractions and soft tissue treatments to eradicate infection in adults, a pattern emerges which is limited to essentials, which is practicable from the financial standpoint, and which has the merit of attacking the problem of dental disease in the only way which can ever succeed — through prevention and control.

Although this long-range approach, emphasizing prevention and control, has still to be translated into effective action in the program for FSA borrowers, a start has been made and in many rural counties there is now a skeleton framework around which there can slowly be built a sound structure.

Organized payment by FSA families for dental service first emerged as part of the medical care program. With but few exceptions, the medical care plans which include dental service provide emergency extractions only. This development reflects the concern of physicians with the systemic effects of focal infection. As of June, 1941, 15,493 families, or 14.7 percent of the total enrollment in the medical care program, were entitled to limited emergency dental services along with various medical services.

The desirability of separate and more complete dental care plans has long since been recognized, and direct negotiations between state and local dental societies and the Farm Security Administration are being fostered actively by the American Dental Association. As of June, 1941, the dental care program had been expanded to include 159 separate dental care groups in 167 counties in 14 states. These groups had a total enrollment of 23,450 families, or 124,021 persons.

The following table illustrates the full extent of FSA dental care activities at the end of the fiscal year, showing both the separate program and the emergency dental care coverage of members of medical care groups.

Separate Dental Care Groups and Medical Care Groups Offering Dental Service as of June 30, 1941

		No. of Units	No. of Counties	No. of Families	No. of Persons
U. S. Total	All	272	334	38,943	202,867
	Separate	159	167	23,450	124,021
	Combined	113	167	15,493	78,846
Region II	Separate	10	10	225	907
Region III	Separate	4	4	147	741
Region IV	All	6	7	471	2,548
	Separate	1	1	58	380
	Combined	5	6	413	2,168
Region V	All	96	99	17,619	95,247
	Separate	85	88	16,351	88,048
	Combined	11	11	1,268	7,199

		No. of Units	No. of Counties	No. of Families	No. of Persons
Region VI	All	55	57	6,473	32,288
	Separate	51	53	5,367	26,747
	Combined	4	4	1,106	5,541
Region VII	Combined	53	85	7,479	37,696
Region VIII	Combined	29	29	3,926	19,758
Region IX	All	6	9	1,316	7,380
	Separate	5	7	1,138	6,301
	Combined	1	2	178	1,079
Region X	Combined	2	3	205	1,091
Region XI	All	5	6	288	1,530
	Separate	2	3	44	246
	Combined	3	3	244	1,284
Region XII	All	6	25	794	3,681
	Separate	1	1	120	651
	Combined	5	24	674	3,030

The four numbered tables in this section of the report include data for the dental care groups comparable to most of the data assembled in tables relating to the medical care groups. Table No. 7 shows the status of the dental care program in June, 1940, and June, 1941, revealing marked expansion of the program during the fiscal year. Table No. 8 gives the enrollment experience of those dental care units which were in operation throughout the fiscal year, showing membership gains in five states and losses in two. Table No. 9 gives a breakdown of the membership by FSA classification and shows an enrollment of 57.8 percent of eligible FSA families in the areas covered. Table No. 10 includes certain data for each separate dental care unit — the starting date, the membership, the percentage of eligible families enrolled, and, for pooled fund plans, the average annual membership fee.

As of June, 1941, there were 15 dental care units in 16 counties on an "individual" rather than a pooled fund basis. These groups were located in Virginia, Michigan, Wisconsin, Missouri, and Oregon. Their total enrollment was only 354 families. In general they represent an attempt, so far rather unsuccessful, to induce families to borrow or otherwise set aside funds to pay dentists for various services including restorative dentistry revealed as necessary by examination. Reduced fees and the whittling of estimates by committees of dentists have not solved the dollars and cents problem — witness the enrollment of but 14 percent of eligible families in 10 Michigan and Wisconsin counties. An

intensive program of dental health education is undoubtedly called for, but financing would still be an obstacle. The program might catch the imagination of the families if there were provision for "maintenance" at reasonable cost once teeth were placed in a reasonably healthy condition, and if the whole emphasis were placed on prevention and control — on sound teeth rather than on replacements.

More characteristic of the present stage of development of the FSA dental care program is the pooled or common fund plan. Groups similar to those which originated in Arkansas have now spread to Mississippi, Missouri, New Mexico, Ohio, and to all four states in Region V. A more ambitious version of this plan has been started in Utah. Units with pooled funds numbered 144 in June, extending into 151 counties in the ten states, and including 23,096 member families.

In a typical plan of this type, the families each deposit with a trustee an amount which varies with the size of family, often $3.50 for husband and wife plus 50¢ for each child. The dental care fund is then divided into equal monthly allotments. Bills are paid in full or by proration, after being audited by a committee of dentists. The services usually include extractions, treatment of infections, prophylaxis and simple fillings.

In the pooled fund plans in states with most units the average annual membership rates range as follows: from $4.10 to $4.95 in Alabama units; from $3.85 to $6.00 in Arkansas units; from $3.90 to $5.60 in Georgia units; and from $4.25 to $9.00 in Mississippi units. In Missouri and Ohio there is a flat annual rate of $6.00 per family.

The implication of rates at this level, confirmed by reports and studies, is that the dental care provided is chiefly that of an emergency nature. A relatively low percentage of enrolled individuals is found to be receiving service during the year. It is recognized that intensive dental health education resulting in a greatly increased demand for those services listed as available would change the whole character of the program, but this change could be built around the present framework without necessarily disrupting the pattern already established. The chief adjustments required would be financial, although there might also be a shift in emphasis favoring the children as the logical point of attack in a program based on prevention and control. It is fully recognized that the present program is palliative rather than a cure, but having so characterized it, one must add that it is providing some dental care where there was virtually none before, that it has the virtue of eliminating many sources of infection, that it is supplementing the incomes of rural dentists from a relatively new source, and that it represents in a general way what can be accomplished through the families' own financial resources without organized subsidy from public funds.

Through an agreement with the Utah State Dental Association another approach is being tried in the dental care field. Two dental care groups including about 400 FSA families in four counties went into operation on June 1, 1941. In this program the members pledge themselves to continue their membership throughout a five-year period. The services, provided on a "free choice" basis, include an annual examination, cleaning and scaling, treatment of infections, extractions, fillings, and part of the cost of dentures and bridgework. With the expectation that the problem of accumulated defects would be a greater burden at first, the annual membership rates were set at an average of $20 per family for each of the first two years of membership and at an average of $10 for each of the following three year. On the basis of the average net incomes of FSA borrowers in Utah in the 1940 crop season, the $20 rate represents 1.8 percent of net income, the $10 rate represents 0.9 percent, and the $70 over five years represents 1.3 percent. The annual membership rates in the Georgia program, averaging about $5 per family, represent 1.1 percent of the statewide average net income of borrowers in the 1940 crop season. These figures illustrate the principle of basing rates on average ability to pay, but they also throw into relief a serious problem revolving about the issue of intelligent, organized subsidy. Should Georgia families be penalized because they cannot pay? Should dental facilities in rural Georgia remain inadequate for want of dental purchasing power?

The dental care program is still experimental. Various techniques must be tested by experience. In no other field is imaginative experimentation more sorely needed.

Table No. 7

Status of group dental care program June 30, 1940 and June 30, 1941, showing for each region and state the number of units (except units restricting membership to occupants of resettlement projects) number of counties involved, number of families and persons holding membership and number and percentage increase or decrease in the member families during the year.

Region and State	June 30, 1941				June 30, 1940				Increase or decrease* in families	
	No. of Units	No. of Counties	No. of Families	No. of Persons	No. of Units	No. of Counties	No. of Families	No. of Persons	Total	Percent
U. S. Total	159	167	23,450	124,021	67	67	8,893	45,061	14,600	163.7
Region II	10	10	225	907	1	1	23	51	203	922.7
Michigan	8	8	173	662	1	1	23	51	151	686.4
Wisconsin	2	2	52	245					52	
Region III	4	4	147	741	3	3	56	241	91	162.5
Missouri	3	3	58	252	3	3	56	241		3.6
Ohio	1	1	89	489						
Region IV										
Virginia	1	1	58	380	1	1	37	237	21	56.8
Region V	85	88	16,351	88,048	15	15	3,015	14,420	13,336	442.3
Florida	1	1	100	392					100	
Alabama	27	27	9,361	49,771	8	8	2,462	13,500	6,899	280.2
South Carolina	6	6	558	3,267	2	2	177	920	381	215.3
Georgia	51	54	6,332	34,618	5	5	376	4,313	5,956	1584.0
Region VI	51	53	5,367	23,747	48	48	5,025	25,880	342	6.8
Arkansas	44	45	4,285	21,349	44	44	4,408	22,921	- 123	- 2.8
Mississippi	7	8	1,082	5,398	4	4	617	2,959	465	75.4
Region IX										
Utah	5	7	1,138	6,301	2	2	503	2,762	635	126.2
Region XI										
Oregon	2	3	44	246					44	
Region XII										
New Mexico	1	1	120	651	1	1	234	1,470	- 114	- 48.7

* - indicates decrease

Table No. 8

Increase or decrease in number of member families during the fiscal year 1940-41 for group dental care units which had begun operating prior to this fiscal year, and percentage of eligible F S A borrowers who held membership in these units June 30, 1941.

Region	State	No. of Units	No. of Counties	Membership 6/30/41	Membership 6/30/40	Increase or decrease[b] Families	Increase or decrease[b] Percent	Percent of families eligible holding Membership June 30, 19
	U. S. Total	53	54	7453	(a) 6572	(a) 211	(a) 3.2	(a) 47.3
II	Michigan	1	1	26	23	3	13.0	27.4
III	Missouri	3	3	58	56	2	3.6	11.8
IV	Virginia	1	1	58	37	21	56.8	32.4
V		6	6	2145	(a) 1370	(a) 105	(a) 8.1	(a) 93.3
	Alabama	3	3	1383	1278	105	8.2	95.6
	Georgia	2	2	670				87.9
	South Carolina	1	1	92	92			100.
VI		39	40	4429	4349	80	1.8	38.5
	Arkansas	37	38	3733	3806	- 73	- 1.9	34.9
	Mississippi	2	2	696	543	153	28.2	83.1
IX	Utah	2	2	617	503	114	22.7	64.0
XII	New Mexico	1	1	120	234	-114	-48.7	66.7

(a) Exclusive of Georgia units for which 1940 membership is unknown.
(b) - indicates decrease.

Table No. 9

Number of rural rehabilitation, resettlement project and other (mostly tenant purchase) FSA families for whom membership is available in dental care groups (except groups restricting membership to occupants of resettlement projects) and number and percentage of such families and number of non-FSA families holding membership in these groups in each region and state.

Region and State	Eligible Families				Membership June 30, 1941				Non FSA	Percent of eligible FSA families holding membership			
	Total	R.R.	R.P.	Others	Total	R.R.	R.P.	Others		Total (b)	R.R.	R.P.	Other
U.S. Total	39,623	38,536	297	780	23,450	22,598	151	160	497	57.8	58.6	50.8	20.5
Region II	1,574	1,529	33	12	225	220	2		3	14.3	14.4	6.1	
Michigan	1,124	1,084	33	7	173	168	2		3	15.4	15.5	6.1	
Wisconsin	450	445		5	52	52				11.6	85.6		
Region III	788	763		15	147	147				18.7	18.7		
Missouri	491	476		15	58	58				11.8	11.8		
Ohio	297	287		10	89	89				30.0	30.0		
Region IV Virginia	179	179			58	58				32.4	32.4		
Region V	20,393	20,029	136	228	16,351	16,122	133	96		80.2	80.5	97.8	42.1
Alabama	10,779	10,763	1	15	9,361	9,360	1			86.9	87.0	100.0	
Florida	292	292			100	100				34.2	34.2		
Georgia	8,409	8,064	135	210	6,332	6,104	132	96		75.6	75.7	97.8	45.7
So. Carolina	913	910		3	558	558				61.1	61.3		
Region VI	14,342	13,901	128	313	5,367	5,327	16	24		37.4	38.3	12.5	7.7
Arkansas	12,404	11,970	128	306	4,285	4,252	16	17		34.5	35.5	12.5	5.6
Mississippi	1,938	1,931		7	1,082	1,075		7		55.8	55.7		100.0
Region IX Utah	2,167	2,028		139	1,138	644			494	29.7	31.5		
Region XI Oregon (a)					44	44							
Region XII New Mexico	180	107		73	120	80		40		66.7	74.8		54.8

(a) Number of eligible families in Oregon unknown.
(b) Not including non-FSA families and Oregon units.

Table No. 10

Counties having dental care units for Farm Security Administration clients, June 30, 1941, (except units restricting membership to resettlement projects) by region and state, showing average membership fee, number of members and percentage of eligible families holding membership.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	MEMBERSHIP 6/30/41 Families	Persons	(a) Percent of eligible families
ALL REGIONS - 159 units in 167 counties				23450	124021	57.8
Region II - 10 units in 10 counties				225	907	14.3
Michigan - 8 units in 8 counties				173	662	15.4
	Antrim	May '41	Indiv.	20	44	20.7
	Branch	Dec. '40	"	12	54	11.5
	Calhoun	Feb. '41	"	17	81	8.3
	Charlevoix	June '41	"	14	75	18.4
	Cheboygan	Mar. '41	"	25	125	12.5
	Eaton	Nov. '41	"	28	76	10.3
	Emmet	June '41	"	31	150	34.1
	Oakland	July '39	"	26	57	27.4
Wisconsin - 2 units in 2 counties				52	245	11.6
	Dane	Dec. '40	"	9	46	7.5
	Marathon	Mar. '41	"	43	199	13.0
Region III - 4 units in 4 counties				147	741	18.7
Missouri - 3 units in 3 counties				58	252	11.8
	Carroll	July '39	Indiv.	14	49	10.5
	St. Charles	Sept. '38	6.00	31	132	17.8
	Worth	July '40	Indiv.	13	71	7.0
Ohio - 1 unit in 1 county						
	Logan	'41	6.00	89	489	30.0
Region IV - 1 unit in 1 county						
Virginia	Caroline	Oct. '39	Indiv.	58	380	32.4
Region V - 85 units in 88 counties				16351	88048	80.2
Alabama - 27 units in 27 counties				9361	49771	86.9
	Autauga	Apr. '41	4.50	130	650	30.4
	Barbour	Jan. '41	4.75	286	590	100.0
	Blount	Mar. '40	4.50	354	1770	74.4
	Butler	Jan. '41	4.95	493	2937	57.1
	Calhoun	Jan. '41	4.80	231	1293	93.9
	Cherokee	Jan. '41	4.85	80	440	74.8
	Chilton	Jan. '41	4.70	328	1776	93.2
(c)	Choctaw	June '40	4.60	628	3255	100.0
	Clay	Apr. '41	4.20	127	552	64.1

(a) Not including non-FSA families and also membership of Oregon units for which number of eligible families is unknown.

(c) Dentists paid on capitation basis.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	(a) Percent of eligible families
Alabama cont'd.	Cleburne			143	786	100.0
	Colbert			173	910	90.1
	Conecuh			440	2420	97.8
	Cullman	Feb. '40	4.50	301	1511	88.0
	Dallas	Aug. '40	4.75	934	5137	100.0
	DeKalb			121	707	76.1
	Elmore	Jan. '41	4.60	342	1790	100.0
	Etowah	Jan. '41	4.75	550	3925	100.0
	Greene	Jan. '41	4.45	816	4000	100.0
	Jackson	Mar. '41	4.10	97	390	100.0
	Macon			214	1177	100.0
	Marion			591	2692	83.9
	Marshall	Apr. '41	4.75	316	1724	78.8
	Pickens	Mar. '41	4.75	328	1806	100.0
	Randolph	Jan. '41	4.65	156	828	58.6
	Talladega	Jan. '41	4.75	140	776	65.1
	Washington	May '41	4.30	69	316	100.0
(c)	Wilcox	Jan. '41	4.90	973	5513	100.0
Florida - 1 unit in 1 county						
	Marion	July '41	5.90	100	392	34.2
Georgia - 51 units in 54 counties				6332	34618	75.6
(c)	Appling	Jan. '41	4.40	208	1013	68.4
	Baldwin	Jan. '41	5.15	92	584	94.8
(c)	Brantley, Pierce)	Mar. '41	5.50	25	175	59.5
	Brooks	Jan. '41	4.95	156	927	84.3
	Burke	Jan. '41	4.70	120	654	66.7
	Calhoun	Mar. '41	4.50	67	334	79.8
	Candler	Jan. '41	4.50	138	681	81.2
	Clay	Jan. '41	4.50	165	828	86.8
(c)	Crisp	Feb. '41	4.75	110	550	86.6
	Decatur	Jan. '41	3.90	167	631	100.0
	DeKalb	Mar. '41	4.75	63	346	73.3
	Dodge	Mar. '39	4.75	196	1107	79.7
	Douglas	July '40	5.60	62	449	61.4
	Dooly	Jan. '41	4.45	151	740	67.7
	Early	Jan. '41	5.20	55	354	41.7
(c)	Fannin	Mar. '41	4.65	14	75	50.0
(c)	Gilmer	Jan. '41	4.50	82	407	91.1
(c)	Glascock, Warren)	Jan. '41	4.50	126	630	45.8
	Grady	Feb. '41	4.45	100	498	84.0
	Greene	Mar. '40	3.00	474	2512	91.9
	Gwinnett	June '41	5.10	121	758	56.0
	Hancock	Mar. '41	5.00	53	318	51.0
	Houston	Mar. '41	5.40	106	724	77.4
	Jasper	Jan. '41	4.40	96	463	70.6
	Laurens	Apr. '41	4.70	505	2761	100.0
	Lincoln, Wilkes)	Mar. '41	4.90	198	1157	97.1
	Lowndes	Jan. '41	4.90	68	383	63.6

(a) Not including non-FSA families and also membership of Oregon units for which number of eligible families is unknown.
(c) Dentists paid on capitation basis.

Region, State Type of Service		County	Month of first service	Av. annual membership fee	Families	Persons	(a) Percent of eligible families
Georgia cont'd.		Macon	Jan.'41	5.50	120	660	44.9
		Mitchell	July'40	4.70	105	567	48.2
	(c)	Montgomery	Apr.'41	5.00	92	554	92.0
		Morgen	Jan.'41	4.45	152	753	100.0
		Murray	Jan.'41	4.60	114	593	86.4
		Oglethorpe	Feb.'41	4.85	220	1260	90.9
		Peach	Mar.'41	5.15	75	470	65.8
		Rabun	Mar.'41	5.00	75	451	92.6
		Randolph	Jan.'41	4.90	192	1119	87.7
		Rockdale	Mar.'41	4.60	65	328	80.2
		Screven	Jan.'41	4.65	63	334	68.5
		Seminole	Mar.'41	4.90	55	321	77.5
		Stewart	Jan.'41	5.15	76	480	75.2
		Taylor	Jan.'41	4.80	107	607	76.4
		Telfair	Mar.'41	4.60	109	559	51.4
		Terrell	Mar.'41	4.65	106	562	60.2
	(c)	Treutlen	May '41	4.65	55	294	80.9
		Upson	Jan.'41	4.85	60	343	90.9
		Washington	Jan.'41	4.85	250	1437	74.0
	(c)	Wayne	Jan.'41	4.60	45	234	42.1
	(c)	Wheeler	May '41	4.35	80	378	89.9
		Wilcox	Apr.'41	5.10	112	702	70.4
		Wilkinson	Feb.'41	4.65	103	545	80.5
		Worth	Jan.'41	4.75	183	1008	79.2
South Carolina - 6 units in 6 counties					558	3267	61.1
		Abbeyville	Mar.'41	4.90	93	544	84.5
		Berkeley	May '40	4.70	92	589	100.0
		Darlington	Apr.'41	4.95	178	1068	68.5
		Horry	May '41	4.50	97	485	32.9
	(c)	Marlboro	Apr.'41	4.50	41	210	34.5
		McCormick	Mar.'41	5.25	57	371	44.2
Region VI - 51 units in 53 counties					5367	26747	37.4
Arkansas - 44 units in 45 counties					4285	21349	34.5
		Baxter	Mar.'39	5.00	57	278	28.9
		Calhoun	Jan.'37	4.95	124	615	100.0
		Cleburne	Mar.'39	5.50	105	528	31.7
		Columbia	Apr.'39	4.95	136	665	45.6
		Conway	Mar.'39	5.10	126	664	29.0
		Crawford	Apr.'39	4.85	55	314	34.8
		Crittenden, Cross	Apr.'40	4.75	279	1248	97.2
		Cross	Apr.'39	4.60	108	555	54.0
		Dallas	Feb.'39	4.15	68	292	21.3
		Drew	Aug.'39	4.80	70	321	35.5
		Faulkner	May '39	4.40	100	483	23.7
		Franklin			35	183	15.7
		Fulton	May '39	4.50	45	227	19.1
		Grant	May '41	4.50	72	361	100.0
		Howard	Mar.'39	4.40	107	517	28.9

(a) Not including non-FSA families and also membership of Oregon units for which number of eligible families is unknown.

(c) Dentists paid on capitation basis.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	(a) Percent of eligible families
Arkansas	Independence	June'40	6.00	150	846	25.9
cont'd.	Izard	Mar.'39	4.25	69	311	31.2
	Jackson	Mar.'39	4.45	200	981	51.8
	Johnson	Oct.'39	4.50	71	355	46.7
	Lafayette	Apr.'40	4.65	133	708	42.5
	Lawrence	May '41	5.35	67	451	25.3
	Little River	Mar.'38	4.25	236	1062	52.4
	Lonoke	Jan.'39	6.00	40	182	11.8
	Monroe	May '39	4.50	154	775	51.3
	Montgomery	July'39	5.50	107	512	29.1
	Nevada	Jan.'39	4.40	108	518	28.6
	Ouachita	Mar.'38	4.70	63	340	22.3
	Perry	May '41	4.15	50	218	25.4
	Pike	Mar.'38	5.00	32	156	83.1
	Poinsett	May '41	4.20	39	172	29.5
	Polk	Mar.'39	4.50	118	593	39.6
	Pulaski	Mar.'40	3.85	68	254	34.9
	Randolph	Mar.'39	4.35	52	244	26.9
	Saline	Feb.'38	5.30	72	473	100.0
	Searcy	Apr.'40	5.00	37	224	15.4
	Sevier	Mar.'39	4.70	132	716	52.8
	Scott	Mar.'40	4.50	130	632	39.3
	St. Francis	Apr.'41	4.50	42	210	29.8
	Stone	Feb.'39	4.50	93	466	26.6
	Van Buren	Mar.'39	5.15	98	625	32.7
	Washington	Feb.'39	4.70	59	316	19.5
	White			160	832	40.7
	Woodruff	Mar.'39	4.50	62	312	35.0
	Yell	Mar.'39	6.00	156	614	29.1
Mississippi - 7 units in 8 counties				1082	5398	55.8
	Hancock, Pearl River	Jan.'40	4.85	79	450	37.1
	Hinds			46	211	100.0
	Lincoln	May '40	4.25	276	1242	66.0
	Madison		9.00	76	485	17.4
	Monroe	Mar.'40	4.50	420	2103	100.0
	Tippah	Jan.'41	4.50	98	490	32.7
	Warren	July'40	4.90	87	417	82.9
Region IX - 5 units in 7 counties				1138	6301	29.7
Utah	(c) Box Elder	July'40	19.40	125	582	17.8
	(c) Davis	Nov.'37	20.80	31	166	28.2
	Duchesne, Uintah	June'41	19.50	222	1305	41.1
	San Pete, Sevier	June'41	19.50	174	1025	27.8
	(c) Weber	Nov.'37	21.00	586	3223	32.8

(a)Not including non-FSA families and also membership of Oregon units for which number of eligible families is unknown.
(c)Dentists paid on capitation basis.

Region, State Type of Service	County	Month of first service	Av. annual membership fee	Families	Persons	Percent of eligible families
Region XI - 2 units in 3 counties				44	246	
Oregon (a)	Coos,					
	Curry	Sept.'40	Indiv.	23	126	
	Washington	Feb. '41	Indiv.	21	120	
Region XII - 1 unit in 1 county				120	651	66.7
New Mexico - 1 unit in 1 county						
	Taos	May '40	4.70	120	651	66.7

(a) Not including non-FSA families and also membership of Oregon units for which number of eligible families is unknown.

HEALTH PROGRAM FOR RESETTLEMENT PROJECTS

The establishment of resettlement projects not only entailed the obligation of seeking the solution of public health problems intensified in the areas concerned, but also offered an opportunity to develop a more inclusive health program than can readily be attained when dealing with scattered farm families. In general the project families have decent housing and adequate sanitary facilities. There is emphasis on raising livestock and poultry and on producing on the farm those foods essential to proper nutrition. To these basic elements of a health program have been added public health facilities, health centers and public health nurses, and organized plans of medical service.

Health centers have been erected or space in community buildings set aside for the purpose in a considerable number of projects. Community nursing services have been established in an increasing number of projects. As of June, 1941, fifty public health nurses had been employed by the Farm Security Administration to serve as community nurses in these rural homestead projects.

With the cooperation of state and local health departments and practicing physicians the community nurses are conducting an effective program of generalized public health nursing. Although the activities of the nurse may not be confined to the project area, as a rule she serves considerably fewer families than most public health nurses. Consequently she can carry out not only those activities usually found in a public health nursing program but can also assist in maternity cases and in emergency and acute illness cases. When giving the latter type of service, she places the emphasis on demonstrating nursing procedures to the mother or older daughter for it is not intended that the time of a community nurse should be taken up in giving bedside care.

At the end of the fiscal year the preparation of a community nursing handbook had been almost completed. The handbook will outline the duties and responsibilities of the nurses and will include suggested routines. Uniform record-keeping and reporting is to be instituted.

During the fiscal year the medical care program was extended to 19 additional resettlement projects, making a total of 75 projects with medical care groups. As of June, 1941, 35 projects had separate medical care units; 37 had units combined with rehabilitation and other FSA families; and 3 had both separate and combined units operating to serve families in the same project. There were 4148 families enrolled in separate units and 1037 families in combined units, or a total of 5185 project families taking part in medical service plans. These families represented 67.8 percent of eligible families in the projects concerned. The percentage of eligible families enrolled in the separate project groups, approximately 70 percent, is considerably higher than in the combined groups. In the latter the percentage of enrollment of project families is 62.4 percent, a figure almost identical to the 62.6 percent enrollment of rehabilitation borrowers.

Table No. 11 gives detailed information on each separate and combined project medical care unit, including the type of service offered and the average annual membership rate.

The one separate dental care unit in operation, one serving families in two Arkansas projects, is also listed in Table No. 11. Dental service of limited scope is provided on a prepayment basis in connection with medical care units in 14 other projects. In several others, local dentists provide care at the health centers on a low fee basis.

Fifteen resettlement projects, which are either isolated or clearly in need of some special arrangement, are served by full-time or part-time physicians. The full-time resident physicians in eight of these projects are filling a need for additional medical personnel in the areas concerned. An interesting technique has been worked out in the case of the part-time physicians whereby they hold regular office hours each day at the project, or possibly three or four times a week. Necessary home calls are made at the time of these visits, and a surprisingly low number of emergency calls is needed outside of these regular hours. This is a technique which may have some application in defense areas and in communities which have lost their physicians to military duty.

Many of these projects have active health associations which are assuming increasing responsibility for the proper administration of the medical care program. It is not unusual to hear a community manager cite the health association as the most successful organization in the project, and it is gratifying to know that the families often look on the health associations as their own organizations not superimposed or dominated by others.

Much still remains to be accomplished in the project health program. Many projects offer a unique opportunity for an intensive program of health education. If all project personnel will collaborate in promoting a broad health program, and if community organizations are given an opportunity to play an active part, it should be possible to build demonstration programs which may have a wide influence.

Table No. 11

Resettlement projects having group medical care units either for occupants of the project only or in combination with rural rehabilitation borrowers. For combined units the name of the county unit involved is shown under County. Total No. of projects 75; combined 37, separate 34, part combined and part separate 3.

Region & State	Project	County (This column blank if unit is separate unit)	*Type of Service	Membership 6/30/41 Families	Percent of total membership in combined units	Average Annual Membership fee	No. of Project families eligible for membership	Percent Participation
U. S. Total				5185	8.5	21.11	7649	67.8
Region I				427	2.9	23.43	1135	37.6
Maryland	Greenbelt		1	372		24.00	865	43.0
New Jersey	Jersey Homesteads	State	1	8	2.0	17.04	8	100.0
New York	New York Valley Farms	Chenango	123	7	6.6	31.68	9	77.8
Pennsylvania	Penna. Farms	Bradford & Sullivan, Wyoming	1	1	1.9	18.36	8	12.5
			1	1	4.5	18.00	2	50.0
	Westmoreland Homesteads		1	38		18.00	243	15.6
Region II				211		25.83	663	31.8
Minnesota	Duluth Homesteads		3	68		12.00	84	81.0
Wisconsin	Greendale		12	143		32.40	579	24.7
Region III				161	23.8	22.95	295	54.6
Missouri	Security Farms	Mississippi	12	36	40.4	23.00	37	97.3
	" "	Penniscott	"	40	18.5	23.00	40	100.0
	LaForge Farm Project	New Madrid	"	71	32.9	23.00	100	71.0
	Osage Farms	Pettis	"	2	4.0	23.00	68	3.0
	Richmond Tract	Washington	"	1	1.7	23.00	4	25.0
Ohio	Scioto Farm Project	Madison	"	11	23.9	22.34	46	23.9
Region IV				912	29.0	23.72	1202	75.9
North Carolina	Pembroke Resettlement Project	Robeson	1	44	11.8	18.00	62	71.0
	Penderlea Homesteads		"	45		18.00	115	39.1
	Raleigh Homesteads	Wake	"	4	57.8	14.76	5	80.0

* - Type of Service: 1 - Physicians'; 2 - Surgeons'; 3 - Hospital; 4 - Drug; 5 - Dental

Region & State	Project	County (This column blank if unit is separate unit)	*Type of Service	Membership 6/30/41 Families	Percent of total membership in combined units	Average Annual Membership fee	No. of Project families eligible for membership	Percent Participation.
Region IV cont.								
North Carolina	Roanoke Farms		1234	206		30.00	210	98.1
	Scuppernong Farms	Washington & Tyrrell	1	72	70.6	21.96	72	100.0
	Cumberland Homesteads		1	125		16.80	221	56.6
Tennessee	Natchez Trace Project	Henderson	"	9	11.1	18.48	9	100.0
Virginia	Shenandoah Homesteads	Greene, Madison, Page, Rappahan. Rockingham	"	101	60.1	17.88	130	77.7
West Virginia	Arthurdale		1234	106		24.00	137	77.4
	Red House Farms		123	40		12.00	81	49.4
	Tygart Valley Homesteads		1234	160		27.00	160	100.0
Region V				1648	10.9	20.23	1740	94.7
Alabama	Ala. Scattered Farms	Lawrence	1234	3	1.4	19.20	3	100.0
	Coffee Co. Homesteads		"	568		27.00	570	99.6
	Gees Bend		124	87		16.00	94	92.6
	Skyline Farms		12345	116		19.80	142	81.7
Florida	Escambia Farms		"	80		30.00	80	100.0
	Fla. Scattered Farms	Madison	1234	11	9.0	16.82	11	100.0
	" " "	Jefferson	14	30	35.3	15.58	67	44.8
Georgia	Flint River Farms		1234	141		30.00	143	98.6
	Greene Co. Project	Greene	"	100	20.5	15.84	100	100.0
	Ga.Farm Tenant Security	Laurens	"	14	2.8	15.46	14	100.0
	" " " "	Early	"	1	1.1	15.00	2	50.0
	Irvinville Farms		"	100		27.72	102	98.0
	Piedmont Homesteads		15	44		12.00	45	97.8
	Wolf Creek Project	Grady	1234	17	17.0	14.88	19	89.5
South Carolina	Allendale Farms		"	116		26.76	118	98.3
	Ashwood Plantation		1234	140		30.00	150	93.3
	Orangeburg Farms		12345	30		30.00	30	100.0
Region VI				1513	5.2	17.48	1974	76.6
Arkansas	Arkansas Farm Tenant Security		123	50		13.28	50	100.0
	" "	Hempstead	"			15.72	4	

Note: Type of Service: 1 - Physicians'; 2 - Surgeons'; 3 - Hospital; 4 - Drug; 5 - Dental

Region & State	Project	County (This column blank if unit is separate unit)	*Type of Service	Membership 6/30/41 Families	Percent of total membership in combined units	Average Annual Membership fee	No. of Project families eligible for membership	Percent Participation.
Region VI								
Arkansas cont.	Arkansas Farm Tenant Security	Nevada	123			14.76	2	
	" "	Clark	13	5	2.3	16.44	7	71.4
	" "	Pulaski	"			17.40	1	
	Arkansas Valley Farms	Logan	123	1	.7	14.76	5	20.0
	Biscoe		1235	39		13.23	70	55.7
	Central & Western Ark. Valley Farms	Conway	123	6	1.8	14.04	9	66.7
	" " "	Franklin	13	1	.8	12.36	8	12.5
	" " "	Johnson	123	2	2.1	14.28	5	40.0
	" " "	Pope	13	2	1.1	15.36	11	18.2
	Chicot Farms		1345	68		13.53	73	93.2
	Clover Bend Farms		1235	58		15.63	81	71.6
	Desha Farms	Desha-Drew	123	61	13.8	17.64	87	70.1
	Dyess Farms		1234	256		18.32	271	94.5
	Lake Dick			26		14.00	47	55.3
	" "	Arkansas	123	7	4.0	13.90	7	100.0
	Lakeview		1235	76		15.81	130	58.5
	"	Lee	123	25	15.7	17.16	44	56.8
	Northwest Ark. Farms	Benton	"	11	5.4	14.88	23	47.8
	" " "	Washington, Benton	"	7	5.7	14.04	42	16.7
	Plum Bayou Homesteads		1234	141		18.16	154	91.6
	Townes Farms		14	31		15.04	31	100.0
	Truman Farms-St. Francis River Farms		1234	85		18.42	103	82.5
Louisiana	Crew Lake Project		1	40		17.00	105	38.1
	La. Farm Tenant Security	Madison	14	69	27.3	18.12	69	100.0
	Morehouse Parish Project	Morehouse	1			14.88	10	
	Mounds Farms		14	68		18.00	127	53.5
	Northwest La. Farms	Natchitoches	1			15.60	1	
	Terrebonne		"	65		17.00	65	100.0
	Torras Farmstead Asso.	Pointe Coupe	14	23	4.9	17.42	28	82.1
	Transylvania Farms		"	140		24.00	154	90.9

Note: Type of Service: 1 - Physicians'; 2 - Surgeons'; 3 - Hospital; 4 - Drug; 5 - Dental

Region & State	Project	County (This column blank if unit is separate unit	*Type of Service	Membership 6/30/41 Families	Percent of total membership in combined units	Average annual membership fee	No. of project families eligible for membership	Percent participation
Region VI cont.								
Mississippi	Mileston Farms		14	100		16.51	100	100.0
	Tallahatchie Co-op Leasing Association		1234	50		16.16	50	100.0
Region VII				2	.4	30.00	146	1.4
Nebraska	Loup City Farms Hmstds.	Sherman	12345			30.00	134	
	Scotts Bluff Homesteads	Scotts Bluff	"	2	2.2	30.00	12	16.7
Region VIII				98	1.6	19.90	129	76.0
Oklahoma	Okla. Farm Tenant Security	Carter	135	8	4.4	25.00	10	80.0
	" " " "	Grady	12345	1	.3	25.00	2	50.0
Texas	Sabine Farms		123	80		19.20	80	100.0
	Texas Farm Tenant Security	Grayson	12345	3	2.4	19.56	24	12.5
	" " " "	Hill	"	3	1.6	26.00	4	75.0
	" " " "	Limestone	"	3	1.6	17.76	6	50.0
	" " " "	Van Zandt	1			20.52	3	
Region IX								
Utah	Widtsoe Resettlement	Utah-Wasatch	12345	7	3.9	30.00	12	58.3
Region X				151	50.7	40.46	298	50.7
Colorado	Uncompahgre Farms	Delta	12345	53	55.8	35.64	56	94.6
Montana	Big Horn Talluck Farms	Treasure	12	32	3.9	30.00	77	41.6
	Fairfield Bench Farms	Cascade, Teton, Lewis & Clark	12345	64	58.2	50.00	129	49.6
	Milk River Farms	Blaine	12	2	6.5	30.00	36	5.6
Region XII				55	96.5	24.91	57	96.5
New Mexico	Bosque Farms	Valencia	1234	34	2.2	28.00	35	97.1
	New Mexico Farms	DeBaca	123	21	58.3	19.92	22	95.5
			DENTAL					
Region VI								
Arkansas	Truman Farms-St. Francis River Farms			69	67.0	5.16	103	67.0

Note: Type of Service: 1 - Physicians'; 2 - Surgeons'; 3 - Hospital; 4 - Drug; 5 - Dental

MEDICAL CARE FOR MIGRATORY AGRICULTURAL WORKERS

Tens of thousands of migrant farm families, seeking work in the various harvests in Pacific and Atlantic Coast states, and in states such as Idaho, Colorado, Texas, and Michigan, can neither pay for medical attention nor secure it through relief agencies. On the one hand they have perhaps the lowest living standards of any group in the United States, with incomes usually ranging between $200 and $450 a year for a family, and, on the other, they do not meet local residence requirements for relief assistance. Poverty, malnutrition, exposure, and the insanitary conditions under which migrants are forced to live, make them an easy prey to disease. The threat of the spread of communicable disease, as migrants move from one farming area to another in search of work, is a problem which cuts across state lines.

Since 1936 the Farm Security Administration has been helping the states meet some of the most urgent health and housing problems created by this wave of migration. To provide sanitary facilities and temporary shelter, 50 camps, 19 of which are mobile, had been placed in operation by June, 1941 in California, Arizona, Oregon, Washington, Idaho, Texas, and Florida. These camps have a combined capacity of 10,915 families. Each permanent or standard camp has a health center with a public health nurse in charge, and isolation units for cases of contagious disease. A mobile clinic with a nurse in charge is assigned to each of the larger mobile camps. The state health departments assist in providing immunizations and conducting various preventive activities.

Since the spring of 1938, medical care has been provided migrants in California and Arizona through the Agricultural Workers Health and Medical Association, a corporation which the migrants join as members. This non-profit organization, which is subsidized by grants from the Farm Security Administration, is administered by a Board of Directors on which are represented the California State Health Department, the State Medical Association, the State Dental Association, and the Arizona State Medical Association, as well as the Farm Security Administration. Through agreements between the AWH&MA and organized professional groups in California and Arizona, migrant families are receiving necessary medical care, hospitalization, prescribed drugs, and limited dental care.

During the past fiscal year similar medical aid programs were established for migrants in Florida, the Rio Grande Valley in Texas, and in the Pacific Northwest -- Oregon, Washington, and Idaho. The chief difference between these new programs and the original program in California and Arizona is that in the more recently organized programs the medical aid is furnished through the camp clinics. The general effect of this is that medical care is secured most readily by camp occupants and migrants in the general vicinity of Farm

Security Administration camps, whereas, in California and Arizona, membership in the AWH&MA has been extended on the basis of need to migrant families throughout wide areas in both states.

Because of differences in these programs, and the early stage of development of three of them, no effort is made in this report to present a comparative analysis of their operations. With the current adoption of more uniform systems of accounting and reporting, such analyses will become practicable.

Agricultural Workers Health and Medical Association (California and Arizona -- Region IX.) As of June, 1941, the AWH&MA was well into its fourth year of successful operation. Although certain changes in organization and procedure were instituted during the year, the program had become relatively stabilized in its operation.

Medically indigent agricultural workers classed as non-residents of California or Arizona may apply for medical treatment at one of the Association's permanent clinics. emergency clinic centers, or district referral offices. In June 1941, there were 9 clinics in California and 7 in Arizona, and 15 other emergency clinic centers or referral offices had been established in the two states at points of concentration of migratory workers. It should be added that as of the end of the fiscal year, 13 standard camps had been established in California and 3 in Arizona, with a total capacity of over 4,000 families, and also 6 mobile camps in California and 2 in Arizona, with a combined capacity of over 1,600 families.

When a migrant is approved for membership in the AWH&MA, a membership card good for one year is issued entitling him and his family to care furnished by local physicians who serve in rotation in the clinics or to care on a referral basis, when he may select his physician or dentist from a list of those participating. The Association pays clinic physicians on an hourly or clinic basis, and it makes payment for all authorized referral work, at fees and charges agreed upon, including surgical and other specialist care, x-rays and other diagnostic services, prescribed drugs, hospitalization, emergency dental care -- and even special diets in cases of malnutrition. Elective as well as emergency surgical care, and urgently needed restorative dentistry, may be authorized by the Medical Director or one of the two Medical Advisers of the Association.

As of June, 1941, 13,486 families were active members of the Association, including 54,961 persons. There is a constant turnover, many memberships expiring and others being initiated or renewed. More than 4,000 applications for medical care were accepted in June.

Reports submitted by the AWH&MA indicate that during the fiscal year there were 118,309 clinic visits, 41,951 referral cases and 11,394

hospital cases. Clinic costs totaled $163,787.23, making an average cost per clinic visit of $1.38. Cases referred to outside physicians and dentists cost the Association $469,131.37 during the fiscal year or $11.18 per case, and the cost of hospitalization was $426,115.73 or $37.39 per hospitalized case.

Expenditures of the AFH&MA for all purposes during the fiscal year ending June 30, 1941 were as follows:

Clinic expense	$ 163,787.23
Referral activities	
Physicians	443,452.07
Hospitals	426,115.73
Dentists	25,679.30
Drugs	50,573.11
Nursing	7,185.91
Miscellaneous	14,976.18
Administrative	299,472.47
Total	$1,431,242.00

The true "administrative" expense is much lower than that indicated. The figure given includes salaries, travel and general expense for nurses as well as clerks in the emergency clinic centers and district offices, an activity directly related to the furnishing of medical aid. Such expenditures should probably be considered as operating costs. True administrative and overhead costs would probably include only the salaries and travel expenses of the Medical Director, Medical Advisers, business, statistical and clerical employees at the main offices, and also general expenses in conjunction with these offices.

Because of the lack of suitable hospital facilities in the area and the difficulty of handling maternity and other cases in camp dwelling units and shelters, the AFH&MA operates a 55 bed convalescent center at Eleven Mile Corner, Arizona. This center, the "Burton Cairns Convalescent Center", was placed in active operation on January 18, 1941. Reports for the period from that date through June 30, 1941, indicate that 455 persons were hospitalized, including 35 obstetrical cases and 85 minor surgical cases (arrangements had not yet been made for handling major surgical cases at the Center). A total of 2,678 days of hospital care was provided during the period.

The operation of the Agricultural Workers Health and Medical Association involves an interesting combination of medical care principles and techniques. In general free choice of physician is preserved, through the panel type of service, but in consultation with the medical societies the panel system has been modified by the introduction of clinics which make it possible to reach more people at a reduced cost. The program utilized both the fee schedule, for office and hospital

practice, and salaried physicians working in the clinics. It is hoped that the Burton Cairns Convalescent Center, and another one planned, will provide more extensive medical service than has been possible in the past and will further reduce operating costs.

Migratory Labor Health Association (Florida -- Region V). During the fiscal year three standard camps were in active operation, the Osceola Camp for 159 white families (with 151 more units under construction), the Okeechobee Camp for 346 colored families (230 additional units almost completed), and the Pompano Camp for 316 colored families. Two additional camps nearing completion, with a combined capacity of 503 families, were to begin operation early the following fiscal year.

Pending the organization of an association similar to the AWH&MA, the serious health problems of the camp occupants were handled by employing public health nurses to serve each camp and by having local physicians serve regular hours in the clinics under government appointment. Direct financial assistance was extended when hospitalization was required. With the organization of the Migratory Labor Health Association, the program since January 1, 1941, has been analogous to that in California and Arizona. The Florida Medical Association and the State Health Department have representatives on the Board of Directors of the Association. The aims of the Association, which is financed by the Farm Security Administration, are to provide physical examinations of all persons registered, to record and attempt to correct physical disabilities, to provide necessary medical, hospital and dental care, to stress proper prenatal, delivery and postnatal care, and to locate and provide immediate treatment for cases of venereal disease.

Local physicians hold daily clinic sessions, and they are on call for emergencies. Definite provision is to be made for dental care, through local dentists holding regular hours at the clinics, and through a mobile dental unit for the colored families.

From January 1 to June 30, 1941, with the program just getting underway, there were 7,309 clinic visits and 22 hospital cases handled by the Migratory Labor Health Association. The Association's expenditures for the period were distributed as follows:

Nursing	$1,618.00
Other clinic expense	2,306.74
Referral activities	
Physicians	508.00
Hospitals	770.79
Dentists	21.00
Drugs	5.00
Miscellaneous	196.79
Administrative	3,711.40
Total	$9,137.72

The fact that administrative costs are relatively high at first, in any new program of this sort, is reflected in the above statement of the early expenditures of the Association.

At the end of the year plans were made to provide for the construction of a convalescent center similar to that at Eleven Mile Corner, Arizona, designed to meet the needs of migrants in the Lake Okeechobee area. This center was expected to be in operation early in 1942.

Texas Farm Laborers Health Association (Texas -- Region VIII). To meet the urgent needs of migrants in the Rio Grande Valley, four standard camps had been placed in operation prior to the past fiscal year (Raymondville, Robstown, Sinton and Weslaco), and two more were established toward the end of the fiscal year (Crystal City and Princeton). These six camps have a combined capacity of 1,397 families. A seventh camp (Harlingen) was to open in August, 1941.

The health program for migrants in the Rio Grande Valley is similar to that in Florida, being confined for the most part to camp occupants and migrants in the general vicinity of the camp clinics. Since December 16, 1940, the program has been administered by the Texas Farm Laborers Health Association, a corporation financed by the Farm Security Administration. The Association employs nurses to serve in each camp clinic under the direction of a supervising nurse and the part-time Medical Consultant. Local physicians hold regular clinic sessions at the various camps. Cases needing specialist treatment are referred to other physicians, surgeons, and to nearby hospitals.

During the period December 16, 1940 to May 31, 1941, the distribution of expenditures of the Association was as follows:

Clinic expense (including nursing)	$ 11,910.97
Referral activities	
Physicians	5,387.50
Hospitals	2,043.35
Drugs	288.90
Miscellaneous	51.22
Administrative	5,254.34
Total	$ 24,936.28

During this period there were 8,877 clinic visits, 1,431 referred cases, and 56 hospital cases. Considerable expansion in the program was anticipated in the next fiscal year. It was expected that administrative costs, which it is natural to find relatively high at first, would become reasonable as the program expanded.

Agricultural Workers Health Association (Idaho, Oregon, Washington -- Region XI). As of the end of June, 1941, six standard camps with a

capacity of 1,423 families, and eleven mobile camps for 1,830 families, had been established in the Pacific Northwest.

Throughout the fiscal year medical services were made available to camp occupants by placing local physicians under government appointment to serve in the clinics and by extending direct financial assistance to migrant families in the payment of hospital and specialist care bills. The camps were served by public health nurses on government salaries. Although the organization of the Agricultural Workers Health Association was completed in March, 1941, it was not to take over the actual administration of the medical aid program until July 1. The Agricultural Workers Health Association is a corporation financed by the Farm Security Administration.

During the fiscal year FSA expenditures for the camp health program in Region XI, exclusive of administrative costs, were as follows:

Nursing	$12,321.00
Other clinic expense	9,566.00
Referral activities	
Physicians	6,884.00
Hospitals	16,416.60
Total	$45,187.60

Reports indicate that 9,083 cases were treated during the year. It was expected that the program would be expanded the next fiscal year to cover migrant families in areas adjacent to the camps. Moreover, a nursery and school hot lunch program was to be added, and also at least one mobile dental unit.

The studies instituted in the fiscal year 1939-40 for the purpose of securing definite information on the extent of chronic disease and physical impairment among FSA families, through physical examination, have been continued during the past fiscal year. Examinations were conducted in sample counties in eight more states besides the nine in which these examinations had been completed prior to July, 1940. The seventeen states in which these physical examination studies were carried out are as follows:

State	County	Month of Examinations	Number Examined Families	Persons
Georgia	Worth	November 1939	138	759
North Carolina	Avery	December 1939	64	239
Arkansas	Pope	January 1940	177	823
Louisiana	Franklin	March 1940	231	1121
Mississippi	(Carroll	March 1940	128	637
	(Leflore			
	(Humphreys			
South Carolina	Kershaw	April 1940	179	1078
Florida	Levy	June 1940	183	738
Nebraska	Howard	June 1940	120	556
Ohio	Champaign	June 1940	112	429
Colorado	Phillips	July 1940	99	394
Indiana	Montgomery	July 1940	106	355
Texas	Panola	July 1940	114	488
Texas	Runnels	August 1940	70	311
Texas	Williamson	August 1940	80	333
Maine	Aroostook	August 1940	156	884
Missouri	Calloway	August 1940	165	675
Oklahoma	Okfuskee	August 1940	167	814
Virginia	Spotsylvania	August 1940	78	330
Tennessee	Henderson	November 1940	113	533
17 States	21 Counties		2,480	11,497

In April, May and June 1941, a physical examination study was also made of 4,133 persons representing 844 families for whom a special rehabilitation project has been instituted in southeastern Missouri. The counties represented by these families are Butler, Dunkirk, Mississippi, New Madrid, Pemiscot, Scott and Stoddard Counties. Detailed findings from the examination of this group are not yet available.

A uniform procedure has been followed in all of the examinations. Clinics were set up at some central point in each county, ordinarily in a school building. Transportation was arranged for those families who had no way of getting to the clinic. Medical examining and laboratory equipment was taken from clinic to clinic in a small trailer. Two complete sets of such equipment were in use during the examinations. Teams of professional workers were brought together in each state with

the assistance of the university medical schools and state health departments. A typical examination staff consisted of from fifteen to twenty persons. The medical staff ordinarily included an internist, a pediatrician, a gynecologist, one or two specialists in diseases of the eye, ear, nose and throat, and a pathologist. There were in addition a dentist, one or two laboratory technicians, a staff of nurses, and several psychologists (ordinarily four). All professional workers were adequately trained in their respective specialties. As a rule, at least two members of each medical staff were practicing physicians of long experience. The remaining physicians were either in hospital residencies or had just completed residencies of at least two or three years in their special fields.

The study was supervised by medical officers of the Farm Security Administration who maintained as much uniformity as possible in the conditions under which the clinics were held in the different states. Standard examination forms were used, and while different professional staffs were engaged in each state, wherever feasible certain of the professional workers were carried over from one state to another to assist in different examination clinics.

As a rule males fifteen years of age and over were examined by the internist, the specialist or specialists in the fields of eye, ear, nose and throat, the dentist, and the psychologists. Females fifteen and over were routed through the same channels except that their general physical examinations were ordinarily performed by the gynecologist instead of by the internist. All children under fifteen were examined by the pediatrician (two pediatricians were engaged in certain areas), and all except infants received eye, ear, nose and throat, and dental examinations. In general, the psychometric examinations were performed only on individuals fifteen and over.

Laboratory studies included urinalyses, hemoglobin determinations, and either a complement fixation or flocculation test for syphilis, or both. In the different areas there was some variation in the age grouping of children under fifteen who received these laboratory examinations. Other diagnostic studies which were not routine but which were conducted in certain areas included stool examinations for intestinal parasites, blood examinations for malaria, and chest x-rays for tuberculosis. A few other special studies were conducted such as vitamin deficiency studies.

The results given below represent some of the findings in the examination of 11,497 persons in 2,480 families in the 17 states listed above. Those examined included 9,776 white persons in 2,169 families and 1,721 colored persons in 311 families. For less common defects such as disease of the nasal sinuses, cardiovascular defects and arthritis, the findings are limited to observation of 5,905 white persons in 11 states and 993 colored persons in 5 states.

The most prevalent defect was that of dental caries. Sixty-nine percent of the white persons examined, and also of the colored, were found to have dental caries. If the group observed is limited to younger individuals between 15 and 30 years of age, the percentage with caries rises to 84 percent (85 percent for white, and 79 percent for colored persons). This indicates that the percentage of persons with caries decreases in the higher age groups, presumably due to the number of extractions that have been performed as an end-result of caries.

Clinical diagnoses, having a definite nutritional aspect, indicate that malnutrition was diagnosed in 8.5 percent of the white children under 15 years of age and 5.6 percent of the colored. In this same group rickets was diagnosed for 2.7 percent of the white children and 5.9 percent of the colored, with residual effects of rickets found in 3.2 percent of the white children and 4 percent of the colored.

Normal vision according to the Snellen test was found in 68 percent of the heads of white families under 45 years of age, and in 52 percent of the wives in this age group. When we study the degree of variation from normal vision, we find that 5 percent of these heads of families and 9 percent of the wives under 45 show 20/40 or worse in the better eye. Among the heads and wives 45 years of age and over, 27 percent and 50 percent respectively tested 20/40 or worse in the better eye. Seventy-four percent of the white children under 15 were found to have normal vision in both eyes, and only 4.1 percent showed defects of 20/40 or worse in the better eye. Blindness in one eye was found in 4 per 1000 and in both eyes in 0.5 per 1000 among all white persons examined. Among the negroes examined, the results of the Snellen test for vision were consistently better than those for the white group. Normal vision in both eyes was found in 82 percent of the heads of families under 45, as compared with 68 percent for white persons, and among 76 percent of the wives under 45, as against 52 percent in the comparable white group. Normal vision was found in 90 percent of the colored children under 15, as against 74 percent of the white children.

For the ear, nose and throat defects there were found, among every 1000 white persons, an average of one person deaf in one ear, two persons deaf in both ears, 79 persons with impaired hearing in one ear, and 29 with middle-ear disease. Six percent of this group had diseased sinuses, and deflected nasal septum was found in 26 percent. Among 9,649 white persons of all ages in 17 states, 55 percent had defective tonsils. The figure for white children under 15 years of age was 57 percent. Among 1,702 colored persons of all ages, 58 percent were found to have defective tonsils. The rate for colored children under 15 years of age was 70 percent.

When we come to the circulatory system, we find various defects which may have a distinct bearing on the possibility of rehabilitating an individual. Among the white families, a clinical diagnosis of

hypertensive vascular disease was made in 6 percent or 13 percent of heads of families and wives, hardening of the arteries in 1.8 percent of 4.2 percent among heads and wives, and other diseases of the heart in 5.2 percent of the group. Congenital defects of the heart and circulatory system were found in 0.8 percent of the children.

Among 1188 white heads of families and wives from 35 to 44, the group in which the median ages of both heads and wives fall, a systolic blood pressure of 140 and over was found in 29.8 percent of the heads, with readings of 150 and over being found in 12 percent, and 160 and over in 5.9 percent; and the wives showed a systolic pressure of 140 and over in 41.2 percent, 150 and over in 27 percent, and 160 and over in 14.4 percent.

Two common handicaps are varicose veins and hemorrhoids. Fourteen percent of the heads and wives in white families had varicose veins. Fifteen percent of the white persons 15 years of age and over had hemorrhoids.

Gastro-intestinal findings include a few cases of peptic ulcer, chronic appendicitis, gall bladder disease and enteritis, but the chief interest in this field is found in the incidence of hernia. The highest incidence was found in the heads of households. Not counting enlarged inguinal rings, various types of hernia were found in 6 percent of the heads of families under 45 and in 12.8 percent of heads of families 45 and over.

Genital tract findings in the females are of particular interest. Perineal lacerations, the result of childbirth injuries, were found in 46.5 percent of white wives under 45 and in 67.8 percent of those 45 and over. Taking the two groups together, first-degree lacerations were diagnosed in 11.1 percent, second-degree lacerations in 32 percent and third-degree in 9.6 percent. Moreover, 20 percent of the whole group had not only perineal lacerations but cystocele or rectocele, or both. Among colored wives, 43 percent had perineal lacerations and 10 percent had cystocele or rectocele, or both, accompanying perineal lacerations.

One factor in the childbirth injury situation is the kind and amount of obstetrical care received. A related factor is the number of children born and the interval between births. We have certain data on the number of children born to 1889 white wives in 17 states. One hundred and fifteen of these wives were childless. The remaining 1774 had borne a total of 8,295 children, or an average of 4.68 children per mother. Of these, 962 children had died, or 11.6 percent. Five or more children had been born to 46.9 percent of the whole group. One wife out of every 14 had given birth to 10 or more children. Fourteen of the wives had borne 15 or more children. The largest number of children for one mother was 19. For the whole group, including childless women, the average number of children born per woman was 4.4.

Another group of handicapping defects is that which includes arthritis and various bone and joint conditions. Out of every 1000 heads and wives in white families, arthritis was diagnosed in 39 and other diseases of the bones and joints were found in 6. The loss of hands, arms, feet or legs was noted in two per 1000 heads and wives, impairment of such parts in 31, loss of fingers or toes in 4 and their impairment in 11. Flat feet were found in 38 per 1000 heads. Spinal curvature was found in 14 per 1000 children under 15 years.

A general summary of the physical defects* found has been made in the case of 5,862 white persons in 11 of the 17 states and 1,038 colored persons in 8 of these 11 states. Among 2,371 white heads of families and wives there were 4.9 defects per person, with 2.4 for 2,556 children under 15 years of age, and 3.6 defects per person for the white group as a whole. Among the colored persons there were 3.3 defects per person — 4.3 for 330 heads of families and wives, and 2.7 for 489 children under 15 years of age.

The arresting fact about the conditions found in this survey is that a great many of them are preventible or remediable. Adequate medical and dental care would go far toward solving the problem but such care alone is not enough. There must be more public health work, greater emphasis on nutrition and more health education.

* The basis on which defects were counted is briefly as follows: In so far as possible acute conditions such as naso-pharyngitis, conjunctivitis, and chickenpox, have been disregarded. A defect of vision was counted if a Snellen's chart test showed a record of 20/40 or poorer in the better eye. A defect of hearing was counted if the record of hearing a whispered voice was shown as ten feet or less. If the teeth of the person examined were in any way defective or any teeth were abnormally missing, the condition was counted as one defect regardless of the number of teeth affected; defects of the gums where found were counted an additional defect. High or low blood pressure and conditions of the lungs, heart, and glands were counted as defects if they were listed under physical defects at the end of the physical examination record by the examing physician, except that enlargement of the thyroid gland or goiter was counted even if it was not so listed. Skin conditions such as moles or scars were also counted only if listed under physical defects, though other skin conditions of an apparently more serious nature were at times counted on the basis of the notation in the body of the record.

Report on

ENVIRONMENTAL SANITATION

Fiscal Year 1940-1941

Within this fiscal year significant changes have taken place which have had a profound effect upon the environmental sanitation program. While there has been expansion of activities, there has also been a curtailment insofar as area of activity is concerned. This has resulted in a more concentrated effort of supervision with resulting improvement in the quality of work performed. Some of the more important changes are discussed in this report.

New Policy of Procedure. Late in 1940, a revision was made in the procedure governing the mechanics of handling grant funds. For the first time it was possible to refer to the Manual of Instructions for the policy on using grant funds for sanitation purposes. A supplemental instruction on the handling of grant funds for sanitation purposes has been very helpful in establishing uniform policies in the field. This procedure also provided two changes which have been of distinct benefit in reducing the confusion experienced in the field. It permitted the issuance of grant checks to be forwarded to the grant recipients in care of the County Rural Rehabilitation Supervisor. This reduced the work of County Supervisors in the handling of funds. A procedure was provided for pooling of funds for sanitation. This has materially reduced the amount of office routine in payment of construction vouchers and in the general handling of individual bank accounts.

Group Action Replaces Individual Effort. It had been noted earlier in the development of this program that better results were obtained when the program was handled by a group of borrowers interested in this one subject. Certain restrictions on the handling of funds prevented a general adoption of this policy. In 1939, a change in policy permitted the functioning of the program through groups.

Typical of the pattern developed is this example: A group of borrowers who are interested in improving sanitation facilities are called together by the County Supervisors. At such a meeting, a representative of the State or County Health Department is usually present, and also the Regional Sanitary Engineer. Various methods of solving sanitation problems are brought out in the discussion. Subjects also included are tenure arrangements with landlords, landlord cooperation, the participation agreement which will be signed by borrowers to permit the pooling of funds, selection of a trustee who will hold and disburse funds, bonding of trustee, assistance by Health Department, supervision by

skilled laborers and disposal of funds remaining upon completion of work. A committee is generally appointed to represent the group. Usually this committee is an existing committee representing the Marketing and Purchasing Association.

The county sanitary engineers or sanitarians visit each home of the group to make an estimate of funds and materials needed. Grant vouchers are prepared for those not able to provide for themselves in accordance with eligibility requirements. Grant, loan, and other funds are deposited then with the bonded trustee. Bids are taken from a number of dealers for material such as lumber, cement, and hardware. Where a Community Sanitation project is operating by the Work Projects Administration, the material for sanitary privy construction is turned over to that agency for use as needed. The material for screens for doors and windows may be delivered to the National Youth Administration work training centers for fabrication, while the material for repair of wells may be delivered to some central warehouse or direct to the farm.

A skilled laborer is usually selected by the group. This man acts as "straw boss" and assists each borrower on his projected improvements. Usually four or five borrowers form a subgroup to help each other. The skilled laborer then is paid for assistance by the group as a whole, but each member has the privilege of working on his own farm and on his neighbor's farm.

A final inspection is made by the State or County Health Department engineer who approves of the work or recommends such changes as might be needed. Vouchers for materials and labor are paid by the trustee upon a proper certification.

Remaining loan funds are credited to the account of the borrower. Personally-contributed funds remaining are returned to the contributor. Remaining grant funds are used to help an additional or prospective member who is in need of similar services.

Special Area Program. Primary consideration has generally been given to the use of grant funds for sanitation in those areas designated for special problem study or for pre-standard loan borrowers. Some regions had not received approval of areas for special study at the end of the fiscal year and consequently sanitation grant funds were used in areas where sanitation or health problems were known to exist. The policy of using grant funds to help pre-standard cases appears to be sound since loans may be made to standard cases and grant funds are insufficient to aid each borrower for sanitation purposes.

Cooperation with Work Projects Administration. Due to the press of work in connection with National Defense activity, there has been a gradual decline in the number of counties operating Community Sanitation projects. At the end of June 1940, there were 1066 counties having projects, but by June 1941 there were 720

counties operating. The projects in some states have closed down entirely. The outlook for having this agency continue to build sanitary privies is not encouraging.

Cooperation with the National Youth Administration. In many areas splendid cooperation from the National Youth Administration has been received. Through their workshop training centers, it has been possible to have screen doors, window screen frames, concrete well slabs prefabricated, casing and pumps assembled for repair of wells. There has been a gradual decline in this work, however, due to the fact that training activities for National Defense have taken priority.

Cooperation with State and County Health Departments. The amount of aid contributed by State and County Health Departments is extensive. The response has been most gratifying even in those states where trained personnel is sorely lacking. Many State Health Departments have designated one engineer as representing them on this work. Because of the loss of personnel to military service, there appears to be a decline in the amount of supervision received from these agencies.

Consultation Services. In November 1940, Mr. Harry E. Miller, Resident Lecturer in Public Health Engineering and Sanitation, Division of Hygiene, University of Michigan, was appointed Consultant to this office. Prior to this appointment, Mr. Miller served a temporary field appointment for three months as an assistant sanitary engineer. His services were utilized in the twelve states comprising Regions II, III, and VII. The results of Mr. Miller's services were so gratifying that he was requested to serve as Consultant.

As a Consultant, Mr. Miller attended the Annual Conference of Area Medical Officers, Health Services Specialists and Sanitary Engineers held in Washington, D. C. in November 1940. His services were also used during several weeks in June at which time he visited the migratory labor camps in Texas.

Upon the recommendation of Mr. Miller, the Chief Medical Officer requested the appointment of an Advisory Council on Sanitation. This request was granted by the Administrator, and appointment of two additional consultants is pending. In addition to Mr. Miller, it is expected that Mr. Herbert A. Kroeze, Director of Public Health Engineering, Mississippi State Board of Health, and Mr. Harold A. Whittaker, Director of the Division of Sanitation, Minnesota Department of Health, will serve as Consultants on the Advisory Council.

Education Material. Considerable success with educational features of the sanitation program has been attained in Region XII by means of colored slides. Typical illustrations have been pictured on small slides for projecting on a screen. Sets of slides are available for showing different subjects. These are used at group meetings of borrowers.

In other regions, photographs illustrating "before and after" conditions on borrowers' farms have been taken for demonstration purposes.

Annual Conference. All regional sanitary engineers attended the Annual Conference of Area Medical Officers and Regional Health Services Specialists. This was the first time the sanitary engineers had met together. The conference was held in the Burlington Hotel, Washington, D. C., November 13-16, 1940. At that time, much discussion centered on the new procedures affecting grant funds and on reports. It was recognized that there was need for considerable study relative to repairing water supplies. A half day was devoted to the discussion of migratory labor camps.

Reports. Difficulty has been experienced in securing reports from the field upon the amount of constructive work done and the disposition of funds. At the end of this fiscal year, there was no uniformity in the manner in which these data are secured. Some study has been given to this problem but as yet no satisfactory solution has been found.

Resettlement Project Sanitary Inspections. Prior to this fiscal year arrangements had been made for the Regional Sanitary Engineers to render service to those Resettlement Projects in their respective regions. Such service was to include occasional sanitary inspections, especially regarding quasi-public water and sewage disposal systems. A number of inspections have been made this year and a summary is included later in this report.

Tenant Purchase Program. Very little attention has been given by Regional Sanitary Engineers to sanitary facilities for Tenant Purchase farms. Some time has been devoted to conferences with Tenant Purchase engineers. There is need of spot-checking Tenant Purchase farms for sanitary facilities by Regional Sanitary Engineers.

Personnel Changes. Considering that this has been the first full year of duty by Regional Sanitary Engineers, there have been a number of changes made in personnel. At the beginning of the year there were seven sanitary engineers on duty as follows:

Assistant Sanitary Engineer	Region
James P. Slater	II & VII
Lawrence W. Murray	III
Leon S. Blankenship	IV
William H. Bates	V
Robert H. Riggin	VI
George D. Kester	VIII & XII
Eugene M. Howell	IX, X & XI

Because of the vast area covered by Mr. Howell and because of the increasing importance of proper maintenance of sanitary facilities in migratory labor camps in Regions IX & XI, it was necessary to rearrange the areas covered by these men and secure additional personnel.

Mr. Ivan F. Shull was appointed November 13, 1940 with headquarters in Denver, Colorado to serve Regions VII & X.

During this period, there was noted an ever-increasing activity on the part of the Regional Sanitary Engineers and approval was given for a reclassification of the position from Assistant Sanitary Engineer to Associate Sanitary Engineer. By the end of the fiscal year, all reclassifications had been completed.

In February 1941, Mr. William H. Bates, a Reserve Officer in the U. S. Army, with headquarters in Montgomery, Alabama, was called for active military service. In March 1941, Mr. Lawrence W. Murray, also a Reserve Officer in the U. S. Army, with headquarters in Indianapolis, Indiana, was called to active military service.

In order to provide Region I with the services of a sanitary engineer, the area covered by Mr. James P. Slater was changed. His headquarters were continued in Milwaukee, but Region I was added and Region VII transferred to Mr. Shull. As the work in Region I developed, and with the increasing necessity for additional supervision from this office, Mr. Slater's headquarters were changed from Milwaukee to Washington, D. C. on June 1. During June, Mr. Slater devoted full time to Region I. To fill the vacancy created by the transfer of Mr. Slater from Milwaukee, Mr. Herbert A. Anderson was appointed to this position on May 12, 1941.

With additional migratory labor camps being put into service in Region XI, it was necessary to create a new position of Associate Sanitary Engineer in Region XI, with headquarters in Portland, Oregon. Mr. Maurice L. Cotta was appointed to this position on June 2, 1941.

On June 27, 1941, Mr. Gerald M. Ridenour was appointed to fill the temporary vacancy at Montgomery, Alabama, Region V. On the same date, Mr. Paul P. Maier was appointed to fill the temporary vacancy for Region III at Indianapolis, Indiana.

The roster of Regional Sanitary Engineers, as of June 30, 1941, is as follows:

Associate Sanitary Engineer	Headquarters	Region
James P. Slater	Washington, D. C.	I
Herbert A. Anderson	Milwaukee, Wis.	II
Paul P. Maier	Indianapolis, Ind.	III
Leon S. Blankenship	Raleigh, N. C.	IV
Gerald M. Ridenour	Montgomery, Ala.	V
Robert H. Riggin	Little Rock, Ark.	VI
George D. Kester	Dallas, Texas	VIII & XII
Eugene M. Howell	San Francisco, Calif.	IX
Ivan F. Shull	Denver, Colo.	VII & X
Maurice L. Cotta	Portland, Oregon	XI

In cooperation with the Minnesota State Department of Health, Mr. Harold R. Shipman was appointed Assistant Sanitary Engineer, with headquarters at St. Paul, Minnesota. Mr. Shipman functions directly under the administrative control of Mr. Milo G. Flaten, State Director of Rural Rehabilitation.

Study of Materials and Construction Problems. It is apparent from the difficulties experienced in the field that studies are needed on the use of various materials and methods of construction for sanitary privies, screen doors and water wells. During the past year, aid was enlisted from the Forest Products Laboratory, Madison, Wisconsin in studying this problem in relation to sanitary privies. Several small projects are under way in different states in which studies are being made of methods of sanitary well construction. Since such studies require considerable time, no report can be made on progress or work accomplished.

Materials and methods of construction of cisterns, also simple and efficient means of water purification for cisterns are problems that require study. A number of different types of cisterns have been constructed and various means of filtering or chlorinating the water have been tried. A cooperative project is under way in Texas in which a new method of chlorination is being tried out.

All of these studies are aimed principally at reduction of cost of construction with maintenance of high standards of sanitary protection. Ease of construction is also of major consideration. Rising prices of materials, and unavailability of some materials such as galvanized pipe and brass cylinders, have been delaying considerably the advancement of the environmental sanitation program. Priority for Defense will continue to hamper this work unless suitable substitutes are found.

Water Facilities Program. A Water Facilities program for certain designated areas west of the Mississippi River has been of great benefit in carrying out the provisions for domestic rural water supplies. In many instances, it has not been possible, with the limited funds available for environmental sanitation, to make the needed improvements

on the farm water supply. However, by combining the environmental sanitation and water facilities programs, many improvements have been completed on farms where with each working alone it would have been impossible. Expansion of the Water Facilities Program into other areas will do much toward solving some of the troublesome problems of procuring a safe water supply.

Resolution Adopted by Conference of State Sanitary Engineers. At the annual meeting of the Conference of State Sanitary Engineers held in Detroit, Michigan on October 7, 1940, a resolution was adopted by the Conference which reflects the attitude of many of the State Health Departments toward the environmental sanitation work of the Farm Security Administration. The Conference is composed of the Chief Sanitary Engineers or Directors of Sanitation Divisions of the State Health Departments. The following is the resolution adopted:

WHEREAS, the Farm Security Administration has recognized that safe water supplies, sanitary disposal of excreta, and screening are essential for decent living conditions on the farm home, and

WHEREAS, the Farm Security Administration has found the establishment of such living conditions are essential to economic rehabilitation, and

WHEREAS, that Administration has made funds available to promote such improvements for their clients, and

WHEREAS, the Farm Security Administration has recognized the place of the duly constituted health agencies in the establishment of sanitary practices within their jurisdiction, and

WHEREAS, it is recognized by this Conference that such a program constitutes a practical demonstration of recommended health practices in rural sanitation.

NOW THEREFORE be it resolved that this Conference of State Sanitary Engineers, in executive meeting here at Detroit, October 7, 1940, do commend the Farm Security Administration for making it possible to conduct these practical demonstrations in Rural Sanitation.

AND BE IT FURTHER RESOLVED that this Conference commend the Farm Security Administration for their desire and willingness to cooperate with the health agencies in accomplishing these improvements to farm life and that the Secretary be instructed to transmit copies of this resolution to the proper officials of the Farm Security Administration.

Resolutions Committee,

J. H. O'Neill
C. L. Pool
W. W. Towne, Chairman

Rural Rehabilitation Environmental Sanitation

The major portion of sanitation improvements made on farms must of necessity be made when farm work is slack and weather permits. There may be a rather long period between the beginning of a program and its completion. In some counties, where improvements are made by contractors, the lapse of time is relatively short, but where the farmers themselves participate in the work, as is generally done, the time covers the greater part of a year. There are in general two periods when this work is done, in the spring before the plowing is started or in the fall after the harvest. There are variations of this dependent on climatic conditions. For this reason, it was believed inadvisable to attempt to report the amount of work completed as of June 30,1941, since it would represent the improvements completed from two distinct allocations of funds. In Tables No.12, 13, and 14 is found a statistical report upon sanitation improvements made during the calendar year 1940. The allocation of sanitation grant funds for this purpose was made late in 1939. A supplemental report was made early in 1941 and it is reproduced in this report with some additions not available at the time the report was originally made.

Table No.15 shows the allocation of environmental sanitation grant funds for the past fiscal year. It indicates the number of counties in which these funds were distributed, the number of families aided, the total funds allocated by regions and states, and the average sanitation grant per family.

The following is a brief description of the sanitation program as it applies to each region.

REGION I

As far as possible the sanitation program in Region I is being administered through"sanitary program associations" where the associations are either working with the WPA or placing bids for construction of the facilities. Such associations have already been organized in Maine, New Jersey and Maryland, and in the near future they will be organized to carry out the program in New York State.

Grant funds for participating in the sanitation grant program have been made available in restricted areas in the various states, in counties where a special area has been set up, or where it is contemplated that one may be set up.

In southern Maryland, the associations are working on a contract basis with private individuals; in Maine, an agreement has been reached with the NYA wherein the NYA people will construct the facilities. Wherever possible an arrangement will be made with NYA or WPA to construct the privies and screens and make well repairs. Where such arrangements are not possible, the work will be handled on a bid basis and awarded to private individuals.

REGION II

The statistical data contained in this report refer to the sanitation program as it is carried on with sanitation grant funds only. Inasmuch as sanitation grants were made only to pre-standard or non-standard FSA clients in Region II, the data do not give a complete picture of the amount of sanitation work carried on in this region but apply only to these types of clients.

In the three states in Region II, there is also a sanitation program for standard borrowers. The money spent on the sanitation program for standard clients was considerably more than the amount spent as sanitation grants. These funds came from various sources depending on the circumstances of the individual clients, such as loans, personal funds, grants and landlord contributions. Accurate and detailed information as to the amount of funds expended in this part of the program is not available at present. However, efforts are being made to obtain such information and it will be submitted as a separate report at a later date.

The sanitation program in Region II has been carried on largely through the excellent cooperation of the Home Management Supervisors. Cooperative associations are being used to a large extent in the purchasing of necessary materials. This has been especially true of the program in Minnesota and substantial savings have resulted. It is planned to make more extensive use of such associations during the coming year.

The sanitation work has been received enthusiastically by almost all of the borrowers. They are very appreciative of assistance in improving their farms. Their attitude indicates that they have realized the need for improvement but previous to the program have not been able to make these improvements due to lack of funds.

REGION III

The sanitation program has been confined to special areas in each of the five states in Region III. The construction and installation of sanitary facilities is being accomplished on the basis of: (a) materials purchased by FSA cooperative groups, or otherwise; (b) prefabrication by manufacturers, WPA or NYA; and (c) installation by WPA, NYA or skilled workmen selected from among the borrowers. The following is a brief review of the program by states.

Illinois. Originally an effort was made to secure the construction and installation of sanitary facilities with the assistance of NYA. However, progress was considered too slow and a self-help skilled workman method of effecting installations was begun. This method is proving satisfactory. The principal problem still faced is that of developing a closer working relationship with NYA and WPA in the prefabrication of units.

Indiana. The ten sanitation counties in Indiana formed a State Environmental Sanitation Committee which purchased materials for all counties and effected an estimated saving of 15 to 20 percent on materials. Supplies were handled in NYA shops at Evansville and Jeffersonville. Workmanship is reported as being excellent.

However, some difficulty has been encountered in the decreased enrollment of NYA in these shops.

Iowa. The Iowa environmental sanitation program is reported as being on a strictly demonstrational basis in special areas. The principal problem is considered to be that of safeguarding water supplies. In some instances the high cost of installation has made improvements impossible.

Missouri. Sanitation grants have been made both to families living on association owned or rented lands and to standard borrowers scattered over the special area selected for this work. Some difficulty has been encountered in securing easements from land owners but familiarity with the program on the part of landlords has smoothed out that problem. Some difficulty has also been encountered in obtaining lumber at prices previously agreed upon.

Ohio. The sanitation program in Ohio is reported as being received with enthusiasm by health department and school personnel. In two instances members of a board of trade and a local bank have expressed a desire to further sanitation among low-income groups. Scioto County has forwarded a completion report on sanitation activities, indicating that borrowers have contributed as much as ninety-six days of labor on farm and home improvements under pledges of cooperation.

REGION IV

An attempt was made to confine the environmental sanitation program in Region IV to Appalachian or pre-standard counties, and exceptions to this are few. In some of the counties there are no county health departments, and for this reason it was necessary to set up funds on the basis of average cost of the items of sanitation involved rather than the detailed estimate of a sanitarian. One of the major problems encountered was the inability to get the grant requests submitted in sufficient time to permit the correction of any budgetary discrepancies resulting from this procedure.

With the exception of Virginia, approval by the various State Health Departments of the general specifications by which the work is to be done is on file in the Regional Office. The Virginia State Health Department has verbally agreed to approve the general specifications; however, to date, their written approval has not been received. In general, the cooperation from the various State Health Departments has improved over last year. This is probably due to the fact that the State Health Departments are more familiar with the program. Some difficulty has been experienced in getting both the county sanitarians and FSA personnel to see the necessity of preparing contracts for all of the work to be done. In a few cases the cost of construction may have been slightly excessive in the absence of previously executed contracts for such construction on a predetermined job basis.

Table No. 16 shows by states the number of water supplies repaired and the average cost by different types of water supplies. This table is a breakdown of the Region IV information summarized in Table No. 14.

REGION V

Alabama. Environmental sanitation funds were used in special counties in which complete programs were carried out. At the end of this report will be found a copy of a letter from Mr. Theo Ray, County Rural Rehabilitation Supervisor in Dothan, Alabama to Mrs. Nonnie W. Heron, Associate State Director, regarding the sanitation program.

Florida. The thirteen counties in Florida which received environmental sanitation grant funds were selected in collaboration with the State Board of Health and upon the suggestion of district and county Farm Security Administration personnel. Special screening work was done in Florida in Escambia and Santa Rosa Counties in connection with the mosquito eradication campaign being carried out by the Rockefeller Foundation in this area. The disbursement of practically all of the environmental sanitation funds in Florida was made through a group program.

Georgia. Miss Ruby Thompson, Associate State Director for Georgia, writes as follows in regard to the sanitation program there:

> "The first problem we encountered was, I would say, the carrying out of the program without the services of a Farm Security Sanitary Engineer. In the second place, a large number of the engineers of the State Board of Health were called into military service. We have, however, had good service from the State Board of Health considering the small number of engineers scattered over the state. The engineers were able to teach the RR and HM supervisors to make estimates on the work to be done.
>
> In one county where there was such a great need for water supplies, the price for well construction has been almost prohibitive on account of soil conditions (underneath, we found several layers of rock).
>
> Another problem is the advance in price of materials of all kinds.
>
> The Food for Defense Program delayed the completion of encumbering sanitation funds, causing us to lose several thousand dollars of Georgia's fund."

South Carolina. Sanitation grant funds in South Carolina were allocated to nine counties for complete programs including water supplies, screens, and privies. In addition to these nine counties, funds were allocated in Laurens and Greenwood Counties to meet peculiar problems in the area. The Buzzard Roost Power Project, located in the corner of these two counties, has created an unusual mosquito hazard due to the backwater from the lakes, and to meet this problem $3000 was allocated for a screening program.

In addition to the complete sanitation and the special area programs mentioned above, funds have been allocated to a number of counties for the erection of sanitary privies.

Virgin Islands. This year, for the first time, an allocation of environmental sanitation grant funds was made to the Virgin Islands. No information is at hand at this time to indicate the extent of the sanitation program, except that shown in the statistical report.

REGION VI

Environmental sanitation grant funds have been distributed generally throughout the three states comprising this region. To date conditions have not necessitated placing funds in special areas; however, more funds have been placed in areas where malaria is prevalent.

The most serious problem we have had with the sanitation program in Region VI is that we have been forced to build sanitary pit privies by private contract in Arkansas. This has not delayed the privy program, but has increased the cost by approximately $5 per unit.

In addition to the regular sanitation program in Mississippi, approximately $80,000 is being spent for sanitary privies and the mosquito proofing of 2000 houses in the five county special tenure area. There will also be some well improvement work in these five counties.

At the conclusion of the fiscal year 1940-41 there are several things that are evident, namely:

(a) Increased interest shown in the sanitation program by the personnel of the Farm Security Administration.
(b) Better cooperation from State Health Departments and other agencies.
(c) Better quality of work.
(d) Better materials used.
(e) More participation from the landowners and borrowers.

All of this definitely indicates that the environmental sanitation program in Region VI has advanced relatively further than the previous fiscal year's program at a corresponding period.

REGION VII

The environmental sanitation program was carried on in each state on a separate basis. In Kansas, North Dakota and Nebraska, the sanitation areas were more or less concentrated while in South Dakota they were located throughout several districts. In Kansas, the program was confined to the special problem area designated by the Farm Security Administration. In the other states the program was conducted in the areas selected by the State Departments of Health on the basis of the needs of the particular areas.

Considerable difficulty was encountered in the initiation of the regional program, in that a proper coordination of the work between the State Departments of Health and the FSA personnel was not developed until rather late in the fiscal year, and the program was not initiated in time to coordinate it with the regular rehabilitation work of the Farm Security Administration county and district supervisors. Difficulty was also encountered in deciding upon the manner in which the funds

for the environmental sanitation program should be handled in each of the counties. It was not until the month of May that procedure was set up for the pooling of sanitation funds by individuals who received grants. Therefore, the early part of the program was necessarily developed on the basis of individual requirements for sanitation.

In some areas, especially in North Dakota, emphasis was placed on the combining of grant and loan or released funds to accomplish the sanitation work. On the basis of this experiment it is proposed that a pattern be established for integrating the environmental sanitation program with all farm and home plans.

It is recommended that, in the future, grant funds for the purpose of environmental sanitation facilities be allocated on the basis of actual need as determined by the State Departments of Health rather than on the case load. By this method, it will be possible to make the most advantageous use of grant funds. If the problem of environmental sanitation is considered in every farm and home plan, the use of loan and other funds is to be expected in all areas.

REGION VIII

The average cost of sanitary facilities per family is rather high in Region VIII, but this is probably due to the fact that the data represent estimates and not actual cost figures. Most of the funds in the counties are pooled. Therefore, the engineers and supervisors purposely made their estimates higher in order to have adequate funds to complete the improvements and to have funds left over in the pool to care for the needs of additional borrowers.

Excessive rains have greatly retarded the construction program over the whole region. The water table in a number of areas is still too high to complete the water supply program.

Some difficulty is being experienced with the WPA Community Sanitation Projects in Texas. Most of these projects are closed at the present time and there is no information available as to when any projects will be reopened. This situation may force a change in the program, and privies will have to be built by contract or by the borrowers. The Community Sanitation Program in Oklahoma seems to be in better condition at this time. However, Texas has a new statewide project approved by Washington which is being sponsored by the State Health Department.

A simplified system of accounts is being set up by the Finance Division for use in those counties where the money is being pooled, and also for use where the county is operating on an individual borrower basis. It is expected that this system will provide effective control of the funds. A comparatively small percentage of the construction work has been completed on the 1940-41 program.

REGION IX

The personnel in the county offices are much better qualified to make sanitary surveys now than they were a year ago. This is evident from talking with personnel regarding the accomplishments through this phase of the FSA program. The tables showing the use of funds in Region IX indicate a decided trend toward proper protection of water supplies. This too is a sign that the personnel are becomming better educated along the lines of environmental sanitation because, while during the first year advantage was taken of the WPA Community Sanitation Program for the construction of sanitary privies, not much attention was given to improving water supplies. During the second year not only was more attention given to proper protection of water supplies but also to the consideration of proper methods of waste disposal and screening.

The environmental sanitation funds for the fiscal period 1940-41 were used in only two states in this region, $4,973 in Arizona and $19,275 in Utah. Of this amount, $17,500 was used in the Uintah Basin of Utah which has been designated a Special Area. The remaining funds for Utah and the Arizona funds were used to improve sanitary conditions on the regular farms of FSA clients. Approximately $19,000 of the $24,248 used in this region was encumbered during the month of June 1941. Therefore, very little has been used as of June 30, 1941.

REGION X

To this region $32,000 of grant funds for environmental sanitation was allocated. Information compiled in the Regional Office shows that a total of $28,845.49 of these funds was encumbered. The funds provided for the protection of domestic water supplies, sanitary disposal of wastes, and adequate screening of the homes of 638 low-income farm families.

In Montana, Flathead County was designated as a Special Area. Grant funds amounting to $3500 were allocated for environmental sanitation in the area. All of these funds were encumbered. This area was relatively new and undeveloped country until the last few years when large numbers of farmers from dry land areas migrated to the valley. Most of these families had to establish homes for themselves as well as all other improvements on small tracts of unimproved land. The most costly item, as far as environmental sanitation is concerned, was the development of new wells. In most instances the borrowers have done their own work and the Farm Security Administration has furnished money to purchase casing. The wells are dug by hand through the glacial deposit of coarse gravel which serves as a reservoir for the ground water supply.

Unless Water Facilities can develop a statewide program, there is a need for creating special areas in Wyoming and Colorado. This refers to arid and semi-arid areas in both states where ground water is not available at reasonable depths, or if available the mineral

content is such that it is not desirable for domestic or live-stock use. In these areas one of two practices prevail--either water is hauled from municipalities (in many cases as far as fifteen miles) and stored in cisterns, or these cisterns are filled from irrigation ditches. These areas need careful study as to the feasibility of developing community wells or the desirability of diverting irrigation water into settling basins where through sedimentation and chlorination a safe and convenient source of domestic water could be obtained. It is doubtful whether a satisfactory method of treatment of irrigation ditch water on an individual basis can be developed because of the indifference of many of our borrowers to the importance of chlorinating ditch water.

In Montana and Colorado sanitary privies have been constructed for our borrowers by the WPA. In Wyoming these facilities have been constructed either by the borrowers or by private contract. In all the states there has been an increase in the cost of materials. This can be offset by use of less expensive building material for the superstructure. This is particularly true in mountain areas where native lumber is available.

Screening has not presented any special problems. None of the states has definite regulations concerning screening but it has been the policy of the Farm Security Administration to purchase 16-mesh, galvanized screen. Where improvement was being made on a well-constructed house, these screens were put on frames. In other areas where the houses were of log or earth construction, the screens were tacked directly to the building, using beading or laths.

REGION XI

The environmental sanitation program in Region XI has completed a second fiscal year of operation as of June 30, 1941. Five hundred and seventy-five additional sanitary grants have been made available to families in the rural areas for sanitary improvements.

The sanitation grants allocated for Region XI involved activity in nineteen counties in Idaho, four counties in Oregon, and eight counties in Washington.

The program throughout Region XI was conducted in scattered counties, with no part of the program being conducted in special areas.

It has been found that the completion of the required work has been most orderly and promptly accomplished in those instances where the facilities requiring improvement were initially surveyed by a group consisting of a contractor, a home management supervisor and a sanitarian representing the State Board of Health. This made possible a discussion of all details involved from related standpoints, and made it possible for the adjustments and requirements to become a part of the understanding with the contractor. The responsibility for the full completion of the work agreed upon was thus accepted by the contractor as a part of the contract. Upon

satisfactory completion of the work involved a certificate of completion was issued, after inspection, by the State Board of Health.

The usual cooperation extended the environmental sanitation program by the WPA Community Sanitation Program was interrupted in various counties of the three states due to the National Defense activity which was absorbing some of the skilled workers from the Community Sanitation activity. It is hoped that NYA cooperation will serve as a possible replacement in those instances where WPA has discontinued operation. The need for continued operation of the environmental sanitation program in the region is apparent.

REGION XII

The 1940-41 environmental sanitation program in Region XII has operated on an individual borrower basis except in New Mexico, the one state in which the community plan was carried out.

The Water Facilities Program is playing an active part in certain areas in which both plans operate. In several counties in Texas, Water Facilities is to construct cisterns, and Environmental Sanitation is to complete the privies and the screening. In some communities in New Mexico, the Water Facilities will construct community wells and Environmental Sanitation will take care of other sanitation.

There is some discussion at this time concerning the installation of water mains and extensions in some communities where feasible, to take the place of proposed cisterns. It is thought that this plan would eliminate the hazards of hauling water and the maintenance of cisterns.

A simplified system of accounting has been devised by the accounting section for use in the control of the pooled sanitation funds. This system is to be used in the majority of counties having the environmental sanitation program. It is being accepted with considerable favor by the county supervisors. The same system may be used by a county purchasing and marketing cooperative association.

There is attached a statistical report on the environmental sanitation program. It will be noted that there is no report for Colorado, due to the fact that the vouchers were not submitted in time to be paid before the close of the fiscal year. For the same reason, three counties in Texas failed to encumber funds.

There are ten counties in northern New Mexico in the special area program. The sanitation in these counties is being done through the environmental sanitation program. Childress County, Texas is also a special area county.

Summary of Sanitary Inspections Made on Resettlement Projects

REGION I

No inspections were made in this region on resettlement projects this year.

REGION II

Inspections were made at Duluth Homesteads, Minnesota and Ironwood Homesteads, Michigan. At Duluth Homesteads, difficulty with the septic tanks prompted recommendations for repair. At Ironwood Homesteads, operation of the average disposal plant required adjustment and recommendations were made to overcome this difficulty.

While Greendale, Wisconsin is not under the jurisdiction of the region, at the request of the Community Manager a study was made of the milk supply. As a result of this study the Farm Management Supervisor received a two months' training period on the methods of milk control, taking this training with the Kellogg Foundation at Battle Creek, Michigan. A cooperative was formed in Greendale for the purpose of pasteurizing and handling milk. It is anticipated that a standard milk ordinance will be adopted by the Village Council in the near future.

REGION III

Inspection was made of the Lake County Homesteads, Illinois. In view of difficulties with contaminated water wells on this project, recommendations were made to correct the conditions by the elimination of pump pits and the connection between well pit and sewer lines.

REGION IV

The resettlement projects inspected in this region were Christian-Trigg, Kentucky; Pembroke Farms (2 visits), Penderlea Homesteads (4 visits), Scuppernong Farms (2 visits), and Roanoke Farms (2 visits), in North Carolina; Cumberland Homesteads and Haywood Farms, Tennessee; Aberdeen Gardens and Shenandoah Homesteads (2 visits), Virginia; and Red House Farms (2 visits), West Virginia.

The majority of problems found on these inspections were those of contaminated water supplies, caused by improper construction, inadequate waste disposal resulting from insufficient maintenance, and the accompanying problems of drainage. Bacteriological examinations of water supplies of a quasi-public nature were made at most of the projects. These tests have revealed that many of the water supplies are lacking in sanitary protection.

REGION V

Projects visited in this region for the purpose of inspection were as follows: Coffee County Farms and Gee's Bend Farms in Alabama; Escambia in Florida; Pine Mountain Valley Project in Georgia; Ashwood Plantation, Allendale Farms and Orangeburg Farms in South Carolina. Problems found on these inspections were chiefly due to maintenance or lack of maintenance such as leaking pumps, improper drainage at top of well, overflowing grease traps on sewer lines and abuse of screens on houses. At Ashwood Plantation recommendations were made concerning the operation of the sewage treatment plant and also mosquito breeding control on impounded waters.

REGION VI

The following resettlement projects in this region were visited for the purpose of inspection: Lake Dick, Plum Bayou, Farm Tenant Security in Arkansas; Mounds Farms, Transylvania Farms, and Terrebonne in Louisiana; Richton Homesteads, Lucedale Farms, and Mileston Farms, in Mississippi.

The usual problems of clogged grease traps, torn house screens, improper drainage and disposal of wastes were encountered on these inspections. Maintenance of sanitary privies has been given attention in the recommendations. Examination of water supplies by bacteriological tests has been initiated.

REGION VII

Inspections were made at two projects in this region, Grand Island Farmsteads and Two Rivers. At both places vault type privies are in use and these were found to be unsatisfactory.

REGION VIII

The following projects were visited by the Regional Sanitary Engineer in company with a representative from the District Engineer's Office:

Texas	Oklahoma
Nacogdoches Farms (2 visits)	101 Ranch (2 visits)
Sabine Farms (2 visits)	
Beauxart Gardens (2 visits)	
Wichita Valley Farms	
Wichita Gardens	
Dalworthington Gardens	
Woodlake Community	
Houston Gardens	
Sam Houston Farms	
Three Rivers Gardens	

Maintenance of water supplies has been a noticeable problem in this region. Cisterns are in use on a number of projects, and filters provided for the cistern water have been a source of difficulty. Clogging of strainers on wells at Beauxart Gardens has been troublesome. Underground tile fields for disposal of septic tank effluent have given some trouble at various projects.

REGION IX

Three resettlement projects were visited for the purpose of inspection in this region: Casa Grande Valley Farms and Arizona Part-Time Farms in Arizona, and El Monte Homesteads in California. At Casa Grande Valley Farms the sewage disposal units were giving trouble. Garbage disposal was also unsatisfactory. All of the grant offices in this region were visited by the Regional Sanitary Engineer for the purpose of investigating sanitary facilities. A number of unsatisfactory conditions were found through these inspections and recommendations were made to the Regional Director concerning improvements. Since the offices are leased, the adjustments have to be negotiated through the lessors.

REGION X

San Luis Valley Farms in Colorado and Milk River Farms in Montana were visited by the Regional Sanitary Engineer. In both projects the sanitary facilities were found to be adequate and satisfactory. Bacteriological examinations of the water supplies are to be instituted.

REGION XI

One resettlement project was inspected in this region, Boundary Farms in Idaho. Since the well at this project had proved inadequate, a spring was being developed to augment the supply. This was considered satisfactory.

REGION XII

In New Mexico, the New Mexico Farms at Fort Sumner and Bosque near Albuquerque were inspected. Ropesville Farms was visited in Texas. At Bosque, the driven wells installed for the dairy barns proved to be contaminated. These wells were chlorinated several times and finally were cleared of contamination. At Fort Sumner, the cisterns were provided with concrete covers to replace the broken wooden covers. At Ropesville Farms, clogging of drainage lines from kitchen sinks has been a problem. Attempts are being made to remedy this condition.

Migratory Labor Camps and Homes

REGION III

One inspection was made of the Delmo Labor Homes in Missouri. This was made in December at a time when the houses were under construction with none of them occupied. Each home is provided with a driven well equipped with a modified pitcher pump. From the sanitation standpoint, these are considered to be unsatisfactory. Sanitary pit privies have been constructed for each home. Partial screens have been installed on all homes. It is unfortunate that more attention was not given to mosquito proofing since these homes are located in an area where the malaria incidence is high.

REGION V

No inspections were made on the Florida Migratory Camps during this fiscal year owing to a vacancy existing in the position of Regional Sanitary Engineer for the major portion of the year. However, an inspection made late in June 1940, which had not been reported in time to be included in the annual report for 1940, revealed that sanitary conditions in the camps were generally satisfactory. It had been anticipated that disposal of sewage and garbage would be troublesome in these camps. From unofficial reports received in this office, this has proved to be the case. Mr. G. M. Ridenour, who was appointed Regional Sanitary Engineer late in the fiscal year, has had considerable experience with the operation of institutional sanitary facilities and he has planned to make immediate studies of the camps with a view toward improving operation of disposal units.

REGION VIII

The Regional Sanitary Engineer has visited the seven migratory labor camps in Texas to assist the camp managers with problems of sanitation. These visits were distributed as follows: Crystal City, two visits; Harlingen, two visits; Weslaco, four visits; Raymondville, three visits: Robstown, three visits; Princeton, two visits; Sinton, two visits.

For all camps the sanitation problems are generally the same. They may be enumerated as follows:

1. Shelters and homes are not mosquito-proof.
2. It is almost impossible to keep covers on garbage cans.
3. The number of garbage receptacles is insufficient.
4. Comfort stations are inadequately ventilated.
5. Shelters and houses become infested with insects, particularly bedbugs.
6. Sewage disposal plants, where provided, require maximum maintenance and supervision of all the

utility services.

7. Garbage incinerators, where provided, require considerable time and fuel for operation and then consume garbage only partially.
8. Drainage of rain water to prevent breeding of mosquitoes and disposing of waste water about hydrants continues to be perplexing.

A number of these conditions are due to construction that can only be remedied by replacement. Efforts are being made, however, to provide means of keeping mosquitoes out of shelters, keeping garbage cans covered, disinfesting shelters of bedbugs, and proper drainage, and disposal of waste water. Further studies need to be made regarding the operation of sewage and garbage disposal units.

REGION IX

Due to the fact that Regional Sanitary Engineer E. M. Howell has been serving more than this one region during the year, it has been impossible to give as much attention to the migratory labor camps as they required. Since Mr. Howell is now devoting full time to Region IX, it is anticipated that migratory camp sanitation will receive added attention.

The following standard migratory labor camps were visited:

Arisona: Agua Fria, Eleven Mile Corner, Yuma.

California: Arvin, Brawley, Firebaugh, Gridley, Indio, Shafter, Thornton, Visalia, Westley, Winters, Woodville, Yuba City.

Mobile migratory labor camps were visited at the following sites:

Arizona: Big Store, Casa Grande, Greens Reservoir.

California: Calipatria, El Centro, Holtville, Niland, Porterville.

Among the permanent or standard camps, the sanitation problems have been largely overcome because these camps have been in operation longer than in other regions. Disposal of sewage, however, continues to be an obstacle and many of the difficulties cannot be overcome without reconstruction of the disposal units. It is understood that this is being considered for some of the camps. Fouled leaching beds, overgrown with weeds, cause sewage to overflow. Pump houses and screen chambers become flooded with surface water. These conditions can be overcome by reconstruction and by better maintenance.

For the most part, incineration of garbage has been abandoned in favor of burial or dumping on a municipal garbage dump. This appears more satisfactory. Water supplies have given little trouble. Sand and mineral salts in the well at Firebaugh have resulted in a study being made of other possible sources of supply.

Drainage continues to be a problem during the wet season of the year and in the majority of cases this has been ably handled by camp managers.

In mobile migratory camps, the problems of sanitation have not been met as well as in the standard camps. This is natural since the facilities cannot be provided for disposal of wastes as readily as in the standard camps. Pit privies are generally provided for human waste disposal in the mobile units. The type of privy now used has not been satisfactory and various means have been adopted to make them more satisfactory. Further studies should be made in an effort to find a suitable transportable type of privy.

Disposal of waste waters from laundry and showers can usually be solved by using leaching pits. Grease and soap have interfered to some extent in disposing of wastes by this means but grease traps of a simple design will undoubtedly correct this trouble.

Water is usually secured from a municipal supply and generally does not present a problem. Garbage is usually disposed of by burial in pits or by dumping on municipal garbage dumps.

REGION XI

In this region mobile migratory labor camps exceed the standard camps in number. Inspections were made of all standard camps and many of the mobile camp sites. In all, thirty-three visits were made by Regional Sanitary Engineers to camps. This work was performed by Mr. E. M. Howell and Mr. Maurice L. Cotta.

Standard Camps Visited

Oregon	Idaho	Washington
Dayton(3 visits)	Caldwell(4 visits)	Yakima(3 visits)
	Twin Falls (3 visits)	Granger (2 visits)
		Walla Walla(2 visits)

Mobile Camps Visited

Athena	Driggs (2 visits)	Toppenish
Grant's Pass	Idaho Falls	
Gresham	Victor	
Independence	Wilder	
Nyssa	Blackfoot	
Stayton		
Mountain Dale		

The same conditions with regard to sanitation in the migratory camps prevail in Region XI as in Regions VIII and IX. Perhaps the difficulties of securing safe water supplies have been more pronounced in this region than in others. Difficulties in operating sewage and garbage disposal units have been much the same. Maintenance of privies in mobile units has occasioned the same experiences here as in California and Arizona.

In May, Region XI received the full-time services of a sanitary engineer. Since the major part of his time will be devoted to operating problems of the migratory camps, it is expected more attention to supervision will assist in reducing the difficulties encountered.

Conclusions

Rural Rehabilitation Program. The number of families assisted by this program in 1940 was 40,680 at an average expenditure of sanitation grant funds of $46.64. In 1941, it is estimated that approximately 16,458 families were aided at an average cost of $53.52.

The tendency now is to use environmental sanitation grant funds to aid pre-standard borrowers and to use loan or other funds in the case of standard borrowers.

Through increased supervision and fewer areas in which to supervise, there has been a general improvement in the quality of environmental sanitation improvements. Group action by borrowers has greatly facilitated the work necessary to carry out this program.

Curtailment of Work Projects Administration and National Youth Administration activities because of National Defense has hampered the program. Rising prices and unavailability of materials have been noted.

Resettlement Projects. Regional Sanitary Engineers completed 68 visits to 53 resettlement projects this year for the purpose of assisting project personnel, furnishing advice and making inspections of sanitary facilities. Numerous problems were encountered but it has been noted that many of the problems resulting from improper sanitation have already been solved.

Migratory Labor Camps. During the fiscal year, the Regional Sanitary Engineers made 75 visits to 50 migratory labor camps, (counting each mobile camp site as one camp). These visits were made to assist camp managers in solving their sanitation problems. A number of difficulties have beset these camps - most of them operating problems with regard to the disposal of wastes. As long as the camps are occupied by human beings these difficulties will continue to be experienced.

Further Study Needed. Additional study will have to be made to further the use of self-help groups of borrowers. In relation to this is the need of simplification in the design and construction of sanitary privies and water supplies. Further study is needed to perfect sanitary units for mobile migratory camps.

UNITED STATES DEPARTMENT OF AGRICULTURE
FARM SECURITY ADMINISTRATION
Dothan, Alabama
July 3, 1941

REGION V

Mrs. Nonnie W. Heron
Associate State Director
Farm Security Administration
Auburn, Alabama

Dear Mrs. Heron:

We are enclosing herewith report on the Sanitation Program in this county and give below some facts about how the program was handled.

We first contacted the Sanitation Officer, who has been worth a lot to us and has given one hundred percent cooperation in this program. We estimated the cost and then submitted grant vouchers for approval. After receiving the money, the next problem was to train carpenters to do the work. We have tried to keep about four different contractors busy on the houses and privies at all times and have tried to keep at least one contractor on the wells.

The Sanitation Officer and I kept in close contact with all the work while in operation to see that we got all the work done properly. The reason for this close supervision was that we found that it was better to check on the work as it was carried on than to wait until the contractors notified us that they were ready for final inspection and then find lots of changes to be made.

The majority of the landlords have participated in this program one way or another, some with money, some with labor, some with reduction of rent, etc. We have had splendid cooperation from the beginning to the end of this program with both landlords and clients, and all of our clients have shown great appreciation for what has been done for them in this program.

We lack sixteen houses and sixteen privies and twenty-four wells having them all completed. We have four crews working on the program and we have part of the uncompleted jobs under construction and we feel like we will have them completed by the 15th of July. On those that are incomplete we are unable to to give you an estimated figure as to what they will actually cost due to the changes in the prices of material which is changing from day to day. Upon final completion of this job, we will give you another report which will be complete.

Sincerely yours,

/s/ Theo Ray
County RR Supervisor

Table No. 12

ENVIRONMENTAL SANITATION PROGRESS REPORT
AS OF DECEMBER 31, 1940

Summary of Environmental Sanitation improvements completed with average costs by regions

Region	No. of counties	No. of Families assisted	Total Envir. San. Grants made	Av. Grant per Fam. assisted	No. of privies*	Aver. cost	No. of houses screened	Aver. cost	No. of water supplies protected	Aver. cost
I	98	1141	$ 43,012	$ 37.70	802	$26.90	636	$10.02	455	$32.84
II	28	643	39,028	60.70	466	25.47	438	10.11	389	31.15
III	40	3351	95,318	28.44	1938	19.15	394	11.93	255	30.90
IV	200	6265	488,935	78.04	3892	19.40	3702	20.16	3657	42.20
V	184	11,598	324,772	28.00	10,891	19.50	2999	16.78	2094	39.48
VI	134	10,224	450,678	47.15	5632	17.20	6048	14.02	2473	26.85
VII	27	717	33,303	46.44	651	23.34	468	11.86	351	20.32
VIII	120	2381	202,536	76.00	2032	21.14	2093	15.84	2030	41.20
IX	74	1179	59,078	50.11	350	28.60	355	10.80	216	32.50
X	43	717	30,438	44.30	384	26.12	193	9.19	196	22.03
XI	36	1038	59,891	57.70	1038	23.85	1038	11.97	1038	21.87
XII	39	1426	70,437	57.89	1252	21.72	1274	8.47	819	39.19
U. S.	1028	40,680	1,897,427	46.64	29,328	19.96	19,638	14.91	14,023	35.46

* - Includes some septic tanks.

Table No. 13

ENVIRONMENTAL SANITATION PROGRESS REPORT
AS OF DECEMBER 31, 1940

Number of counties, by states, in which environmental sanitation grants were made, number of families assisted, total amount of environmental sanitation grants, and average grant per family

Region	State	No. of Counties	No. of Families Assisted	Total Envir. Sanitation Grants Made	Average Grant per Family
I	Maine	14	191	6851	$ 35.87
	Maryland	6	124	4251	34.28
	New Hampshire	7	17	783	46.09
	New Jersey	7	65	1840	28.31
	New York	17	102	5677	55.66
	Pennsylvania	39	613	22,036	35.95
	Vermont	8	29	1573	54.33
II	Michigan	10	140	7806	56.83
	Minnesota	10	175	11,067	60.45
	Wisconsin	8	328	20.155	60.89
III	Illinois	10	680	22,363	32.89
	Indiana	10	529	10,073	19.04
	Iowa	7	189	10,002	52.92
	Missouri	7	1576	33,770	21.43
	Ohio	6	377	19,110	50.69
IV	Kentucky	47	1410	112,895	80.06
	North Carolina	53	1876	143,838	76.67
	Tennessee	52	1339	107,170	79.00
	Virginia	30	1002	73,397	73.25
	West Virginia	18	638	51,635	80.93
V	Alabama	67	3947	138,106	34.99
	Florida	22	981	41,163	41.96
	Georgia	50	2256	63,842	28.29
	South Carolina	45	4414	81,660	18.50
VI	Arkansas	58	3286	151,761	46.48
	Louisiana	24	1805	101,778	56.38
	Mississippi	52	5133	197,138	38.60
VII	Kansas	5	192	6864	35.76
	Nebraska	8	246	11,425	46.44
	North Dakota	6	129	7491	58.07
	South Dakota	8	150	7523	50.16
VIII	Oklahoma	40	840	68,427	73.00
	Texas	80	1541	134,109	79.00
IX	Arizona	11	239	14,658	54.63
	California	33	406	19,349	38.90
	Nevada	4	52	2662	51.20
	Utah	26	482	22,409	54.80
X	Colorado	31	314	13,303	42.40
	Montana	14	249	8357	33.56
	Wyoming	3	154	8768	56.94
XI	Idaho	25	323	19,955	61.78
	Oregon	2	300	20,000	66.66
	Washington	9	415	19,936	48.04
XII	Colorado	2	121	9,683	72.60
	Kansas	7	185	9,035	52.10
	New Mexico	20	839	35,000	42.25
	Oklahoma	2	42	2,082	50.50
	Texas	8	239	14,637	72.00

Table No.14

ENVIRONMENTAL SANITATION PROGRESS REPORT
AS OF DECEMBER 31, 1940

Number, by states, of sanitary privies constructed, dwellings screened and water supplies protected, with average costs

Region	State	Sanitary Privies		Houses Screened		Water Supplies Protected	
		Number	Av. Cost	Number	Av. Cost	Number	Av. Cost
I	Maine	67	$ 23.22	138	$ 7.09	130	$ 33.20
	Maryland	102	25.00	114	9.59	23	26.43
	N.Hampshire	10	40.98	7	8.59	7	23.12
	N.Jersey	19	20.82	28	9.20	51	23.27
	N. York	63	28.88	69	14.74	84	33.82
	Pennsylvania	530	27.01	262	10.29	137	36.71
	Vermont	11	47.13	18	14.56	23	34.88
II	Michigan	64	27.43	78	13.46	48	30.54
	Minnesota	148	23.08	117	10.29	114	33.42
	Wisconsin	254	26.36	243	8.95	227	30.14
III	Illinois	322	19.50	162	10.00	58	36.46
	Indiana	432	19.00	---	---	---	---
	Iowa	30	23.00	---	---	27	39.44
	Missouri	1004	19.00	132	15.00	100	15.00
	Ohio	150	19.00	100	11.00	70	31.43
IV	Kentucky	1202	26.60	1172	17.85	1139	38.07
	No.Carolina	991	18.08	924	20.83	969	41.00
	Tennessee	872	12.21	843	22.51	762	40.71
	Virginia	541	19.72	406	21.34	429	49.55
	W. Virginia	286	15.09	357	19.12	358	52.98
V	Alabama	3596	28.57	566	17.33	461	45.06
	Florida	549	18.90	489	17.05	407	24.35
	Georgia	2690	16.27	1412	15.65	823	45.87
	So.Carolina	4056	13.60	532	18.93	403	35.34
VI	Arkansas	1888	17.75	2556	10.81	1001	25.35
	Louisiana	1337	19.91	730	16.20	423	29.87
	Mississippi	2407	15.37	2762	16.40	1049	28.02
VII	Kansas	189	22.50	22	6.78	24	44.42
	Nebraska	238	23.58	218	14.22	174	11.37
	No. Dakota	188	27.66	99	10.64	53	19.02
	So. Dakota	136	20.13	129	10.79	100	25.11
VIII	Oklahoma	795	20.30	757	12.90	771	45.40
	Texas	1237	21.99	1336	18.78	1309	37.00
IX	Arizona	94	26.85	100	14.21	74	26.80
	California	160	31.71	145	9.39	67	17.24
	Nevada	51	26.45	49	11.03	32	24.15
	Utah	45	23.75	61	8.50	43	72.30
X	Colorado	123	28.20	118	10.19	100	12.25
	Montana	187	25.20	106	8.48	55	11.63
	Wyoming	74	25.97	69	9.01	41	42.21
XI	Idaho	323	24.59	323	15.83	323	21.35
	Oregon	300	29.01	300	7.47	300	30.18
	Washington	415	19.54	415	12.22	415	16.27
XII	Colorado	111	21.50	113	6.22	119	39.19
	Kansas	167	22.60	154	5.42	154	32.40
	N. Mexico	757	17.95	749	7.50	348	31.80
	Oklahoma	39	24.75	40	14.20	25	23.10
	Texas	178	21.80	218	9.01	173	61.80

Table No. 15

ENVIRONMENTAL SANITATION GRANT FUNDS ENCUMBERED
DURING FISCAL YEAR JULY 1, 1940-JUNE 30,1941

Number of counties by regions and states in which environmental sanitation grants were made, number of families aided, total amount of environmental sanitation grants and average grant made per family.

Region	State	No. of Counties	No. of Families Aided	Total Envir. Sanitation Grants Made	Average Grant per Family
I	Maine	10	150	$ 6,314.87	$ 42.10
	Maryland	2	109	3,476.20	31.89
	New Hampshire	6	8	293.60	36.70
	New Jersey	6	35	1,576.48	45.04
	New York	11	75	3,554.98	47.40
	Pennsylvania	42	355	11,953.58	33.67
	Vermont	3	6	404.40	67.40
Total-Region I		80	738	27,574.11	37.36
II	Michigan	18	175	9,560.37	54.63
	Minnesota	9	183	10,348.72	56.55
	Wisconsin	15	194	13,927.79	71.79
Total-Region II		42	552	33,836.29	61.30
III	Illinois	11	258	15,387.25	59.70
	Indiana	10	192	11,995.35	62.50
	Iowa	3	90	8,778.00	97.95
	Missouri	7	518	24,083.00	46.50
	Ohio	6	183	12,495.00	68.43
Total-Region III		37	1241	72,738.60	58.61
IV	Kentucky	21	292	20,094.11	68.81
	North Carolina	7	339	24,919.00	73.50
	Tennessee	7	149	12,591.01	84.50
	Virginia	6	148	12,999.13	87.83
	West Virginia	8	116	8,546.16	73.67
Total-Region IV		49	1044	79,149.41	75.81
V	Alabama	14	1133	83,757.42	73.92
	Florida	13	487	24,162.74	49.61
	Georgia	29	1074	78,319.15	72.92
	South Carolina	39	1504	43,993.79	29.25
	Virgin Islands	-	129	2,997.00	23.00
Total-Region V		95	4327	233,210.10	53.90
VI	Arkansas	27	1119	56,136.00	50.16
	Louisiana	14	596	34,669.25	58.17
	Mississippi	69	2735	80,400.00	29.39
Total-Region VI		110	4450	171,205.25	38.47
VII	Kansas	10	134	12,770.36	95.30
	Nebraska	8	235	12,863.10	54.73
	North Dakota	7	69	3,342.00	48.43
	South Dakota	10	262	10,856.65	41.43
Total-Region VII		35	700	39,832.11	56.90

Table No. 15 (Continued)

Region	State	No. of Counties	No. of Families Aided	Total Envir. Sanitation Grants Made	Average Grant per Family
VIII	Oklahoma	31	468	$ 41,614.12	$ 88.91
	Texas	47	829	68,791.17	82.98
Total-Region VIII		78	1297	110,405.29	85.12
IX	Arizona	7	58	4,973.00	85.74
	Utah	12	238	19,275.00	80.99
Total-Region IX		19	296	24,248.00	81.92
X	Colorado	27	254	10,269.76	40.43
	Montana	7	202	9,551.25	47.28
	Wyoming	15	182	9,024.48	49.58
Total-Region X		49	638	28,845.49	45.21
XI	Idaho	19	163	10,981.35	67.37
	Oregon	4	202	11,500.00	57.50
	Washington	8	210	10,139.31	48.28
Total-Region XI		31	575	32,620.66	56.73
XII	Colorado	2	none	none	none
	Kansas	2	40	3,130.00	78.25
	New Mexico	12	444	18,623.00	41.94
	Oklahoma	1	20	1,414.00	70.70
	Texas	9	96	4,074.00	42.43
Total-Region XII		26	600	27,241.00	45.40
TOTAL UNITED STATES	42 plus Virgin Islands	651	16,458	$880,906.31	$ 53.52

Note: The column "Total Environmental Sanitation Grants Made" shows the amount of funds encumbered on new vouchers received during the fiscal year and does not reflect the funds paid on vouchers which were held over from the preceding fiscal year.

Table No. 16

Number and Average Cost of Farm Water Supplies Repaired by Types

Region IV - 1939-1940

STATE	Drilled Wells		Driven Wells		Dug Wells		Springs		Cisterns		Total	
	No.	Av.Cost	No.	Av.Cost	No.	Av.Cost	No.	Av. Cost	No.	Av.Cost	No.	Av.Cost
Kentucky	356	$36.94	13	34.87	509	43.19	115	21.56	146	36.26	1139	38.07
No. Carolina	88	41.18	289	35.99	343	46.50	215	36.76	34	54.66	969	41.00
Tennessee	181	45.12	62	31.95	149	47.69	172	30.45	198	43.07	762	40.71
Virginia	44	46.87	35	26.50	202	58.12	121	39.60	27	64.24	429	49.55
West Virginia	66	53.17	4	43.67	135	63.30	141	42.51	12	61.91	358	52.98
Region	735	41.51	403	34.58	1338	48.82	764	34.56	417	43.54	3657	42.20